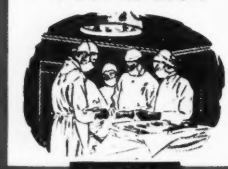
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FEBRUARY, 1946

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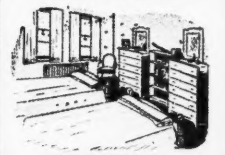
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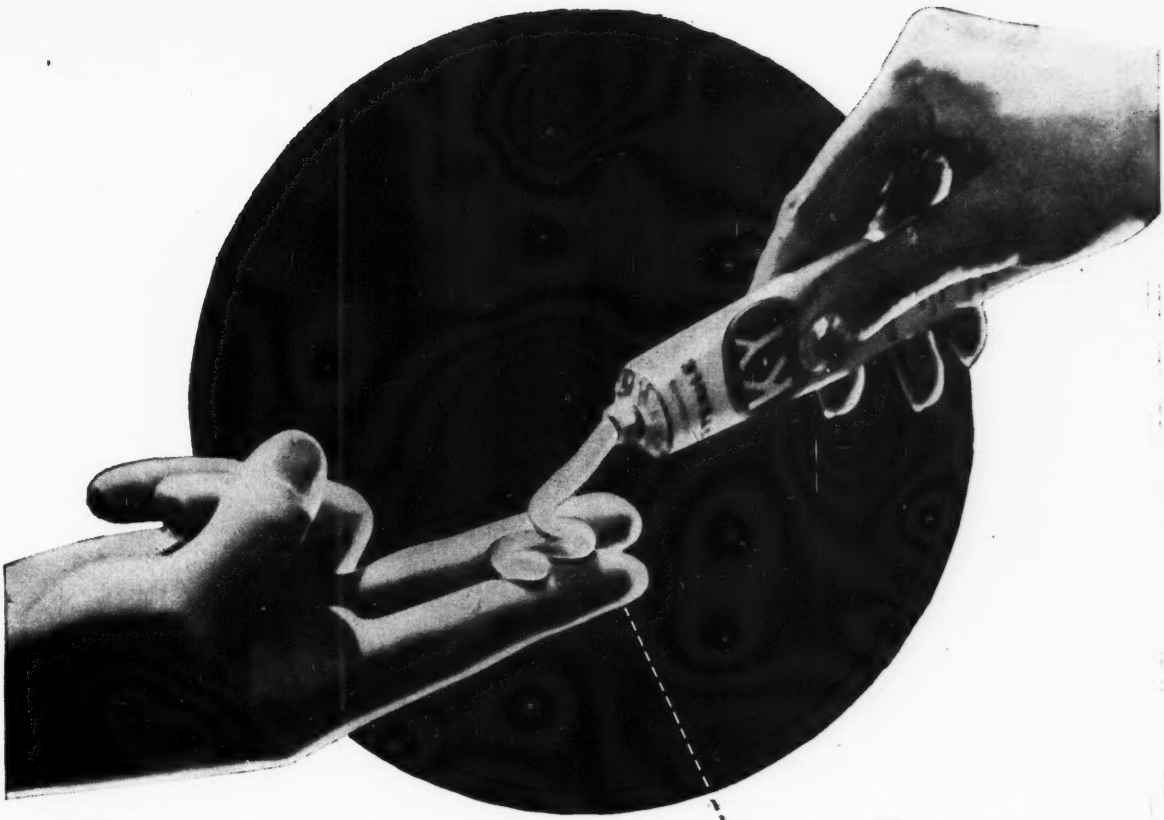
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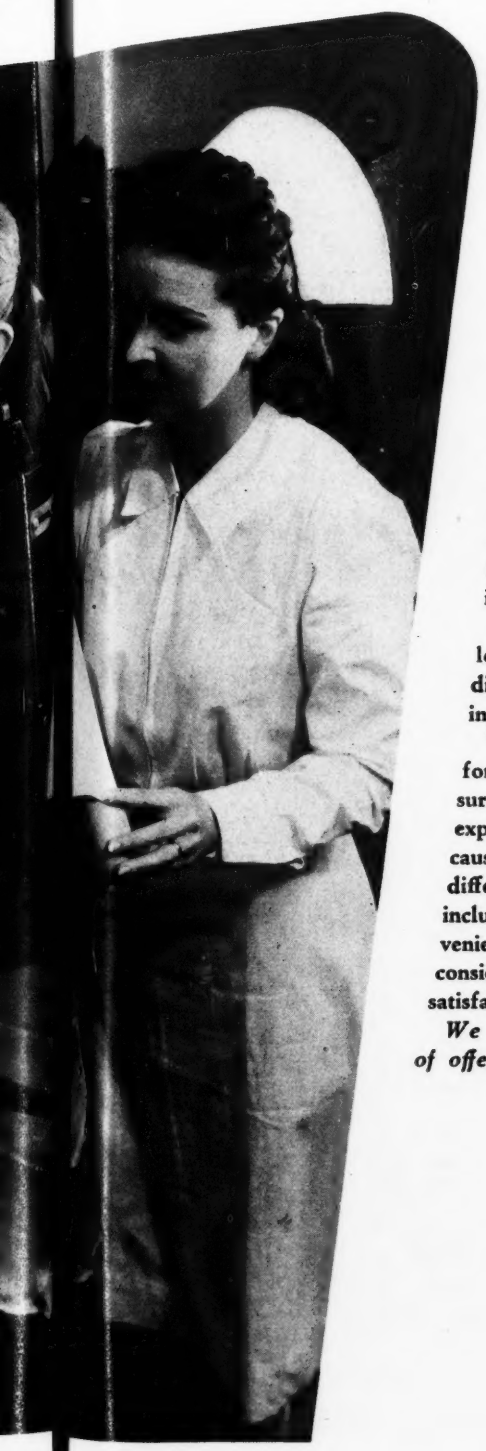
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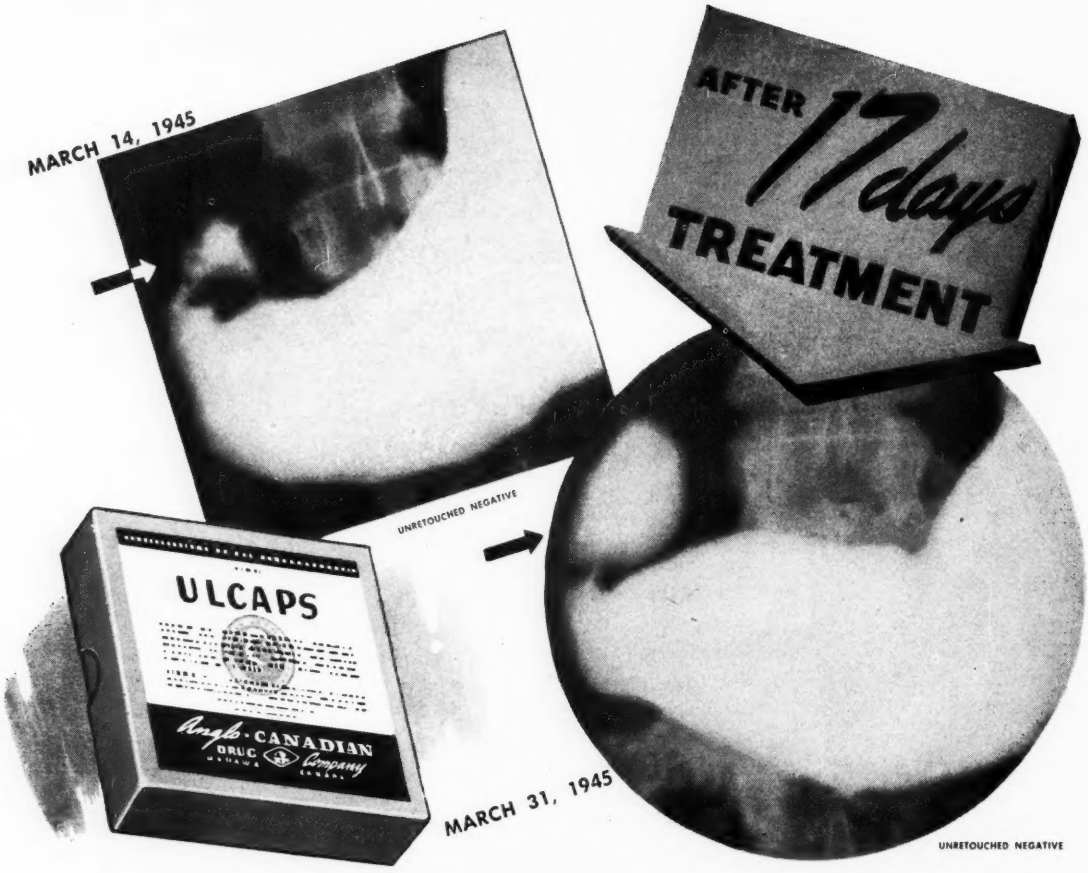
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Across the Desk

By C. A. E.

Physical Fitness Convention

AN invitation from the American Association for Health, Physical Education and Recreation has just been received at Ottawa, asking Canadian leaders in these fields to attend its annual convention in St. Louis.

Addressed to Ian Eisenhardt, chairman of the National Council on Health and Welfare, the invitation points out that the convention will be held from April 9 to 13 and will devote considerable time to the workshop type of meetings. Commercial and educational exhibits are being prepared.

Anyone desiring to attend should write directly to J. Stanley Nantch, 910 Syndicate Trust Building, St. Louis, Mo.

* * * *

Gyro Sunnybrook Library Fund

As a tangible expression of thanksgiving for Victory, the Gyro Club of Toronto has pledged itself to provide the funds for establishing, furnishing and maintaining the finest possible library and quiet room at the new Sunnybrook Military Hospital, Toronto. The privilege and authority for this undertaking has been given to Gyro by the Department of Veteran Affairs, Ottawa, and has been concurred in by the Sunnybrook Hospital Committee, under the Chairmanship of William J. Stewart, M.P.P., and the Corporation of the City of Toronto, who have agreed to have the library administered by the Toronto Library Board as a branch of the Toronto Public Libraries.

In accepting the responsibility for the maintenance of this library and quiet room for our wounded veterans for a period of at least 25 years, the Gyros are motivated by the knowledge that to be effective, remembrance must go beyond the realm of emotion into the field of action.

* * * *

Hon. Russell T. Kelley

Advertisers welcome the news that one of their contemporaries has been made a cabinet minister with the naming of Russell T. Kelley, president of the advertising firm of Russell T. Kelley Limited, Hamilton, as Minister of Health in the Drew Government. Mr. Kelley is a member for Hamilton-Wentworth. We have known Mr. Kelley for many years and have always admired him for his consistent support of many and varied projects in the public interest.

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(Continued on page 16)

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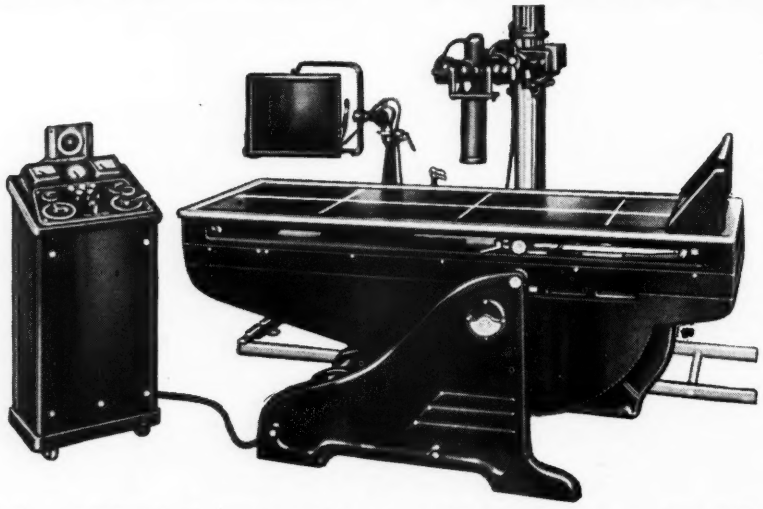
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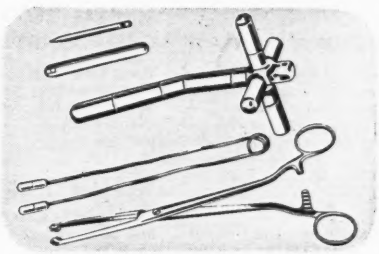
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Across The Desk

Nurse Recruitment in India

A nursing exhibition and recruitment campaign were held in India in November. The estimate of the number of nurses needed for the country is 800,000. The distribution of the present number of nurses (7,000) is statistically one nurse per 55,000 population although the actual disproportion is much greater in rural areas. The Trained Nurses Association of India has worked indefatigably to improve the working conditions and to raise the level of general education for girls entering nursing schools. Standards of nursing are high. The School of Nursing Administration, opened in April, 1943, is the first all India school for graduate nurses. The Association maintained the publication of its Journal throughout the past difficult years, and is recognized by the Central Government as the official advisory body on all matters concerning nursing in India.—*International Nursing Bulletin.*

* * * *

Abbott Laboratories Art Collection

Soon after the declaration of war, Abbott Laboratories commissioned a group of leading American artists to paint a series of pictures dealing with the U.S. Navy's achievements in the various theatres of war. The artists and illustrators chosen included Lawrence Beall Smith, Robert Benney, Howard Baer, Adolf Dehn, Kerr Eby, Don Freeman, Thomas Benton, Joseph Hirsch and George Schreiber.

Recently the collection has been put on exhibition in cities and towns throughout the United States and Canada. During November, "U.S. Navy in Action" was shown at the National Art Gallery in Ottawa. The official opening was attended by Ray Atherton, Malcolm MacDonald, Admiral King of the U.S. Navy, and DeWitt Clough, President, Abbott Laboratories.

From Ottawa, the collection was moved to Montreal where it was shown December 10th-21st at the Art Association of Montreal. "U.S. Navy in Action" opens in Toronto, February 8th, where it will remain until the end of the month, when it goes on exhibition in London and Windsor. Eventually, all paintings will be collected and placed for showing in a new Work Art Museum in Washington.

* * * *

New Dustbane Company in Maritimes

A new Company, which will be known as the Dustbane Maritime Limited, is now being formed to take over the assets in the Maritime Provinces of the Dustbane Products Limited, Ottawa.

The new Company's head office will be in Halifax, N.S., and the products formerly handled by the Dustbane Products Limited, Ottawa, will be distributed by the new Company.

This will be like a homecoming back to the Maritimes as the first factory of the Dustbane Manufacturing Company Limited was opened in Saint John, N.B., in 1907, and the Maritime people who have been supporters for the past 38 years will most likely welcome the news that in the near future the Dustbane line will be handled exclusively by the Dustbane Maritime Limited.

(Concluded on page 20)

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gr. ¼	" " "	gr. 1
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The conception of the West Lincoln Memorial Hospital was a small complete Institution to serve the needs of a section of country between larger Hospitals in Hamilton and St. Catharines, to care for maternity work, minor surgery, highway accidents, convalescent cases, etc.

An outstanding feature of this job by Metal Craft was to furnish not only the proper type of equipment, but to blend into a general colour scheme equipment to make the Institution look home-like, warm, pleasant, and a place in which to get well.

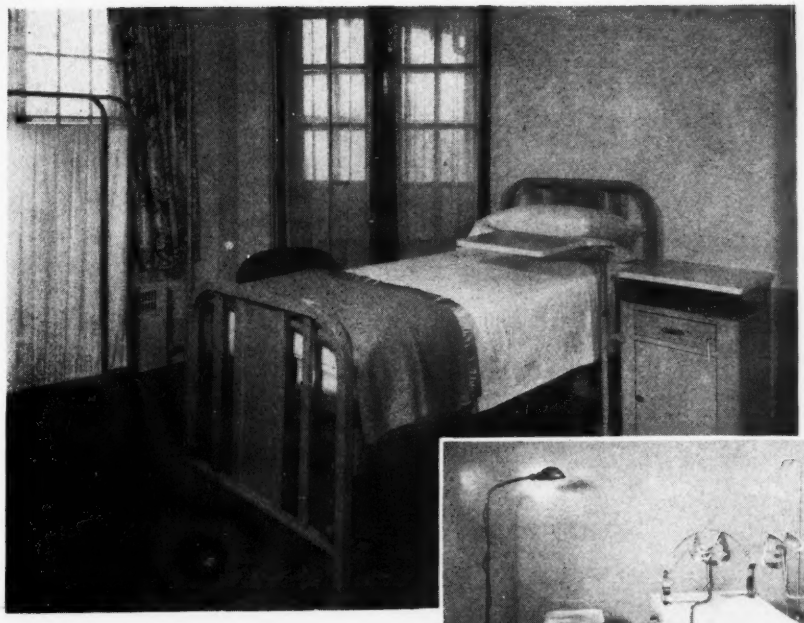
Working from prepared plans, the Metal Craft Company made a study of space allocated and provided equipment accordingly. End-crank beds to enable beds to be moved anywhere, if necessary, against a wall or limited space. Combination bedside tables, which combines an overbed table and bedside table, thus saving space.

In the Nursery, cubicles are laid out to utilize the maximum amount of space to advantage.

The Wards are provided with cubicle curtains, a smooth-running roller on an "I" beam track being the most advanced type of curtain equipment. No hooks to come off the rod in rounding corners, etc. No hooks sewn into the curtain to tear them in the laundry.

In the Operating Room, a Craftsman operating table, with Dunlopillo pad, moderately priced, is admirably suited for the type of work. An emergency light equipped with battery and recharger to keep the battery always ready for instant use. Instrument cabinet of the latest design, rounded corners blend into the surroundings. Special lighting fixture — a four bar fluorescent light, moderately priced, does the job.

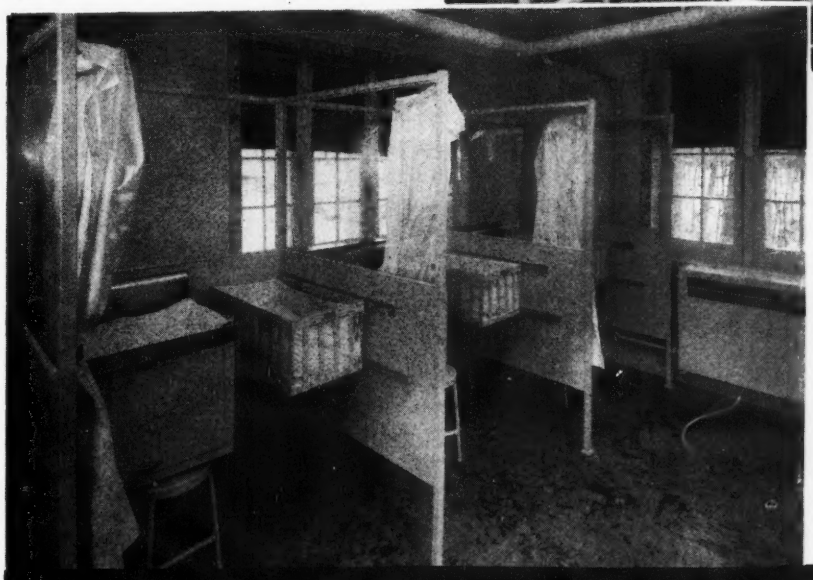
All furniture and equipment is painted in hard baked enamel, shades to match the walls, the drapes, the floors. The layout, as a whole, is pleasing—warm—home-like.



AT LEFT—Modern End Crank Bed, with panel end, and Combination Bedside Table with Formica Top and Leaf in wheat finish, Bed Screen and Easy Chair, all to match, makes an ideal private room suite.



AT RIGHT — The Craftsman Operating Table is designed to provide approved positions. The three sections of top and base is of heavy gauge steel reinforced for rigidity. Table is supplied with knee crutches, shoulder braces, and ether screen, mounted on 4" rubber casters fitted with foot brake.



AT LEFT — This Metal Craft development of a modern Nursery meets the demand for "A Private Room and Bath for Every Baby". The Linen Cabinet with sliding shelf to store linen has stainless steel top and waste receptacle and Dunlopillo pad, usually furnished in cream coloured baked enamel.

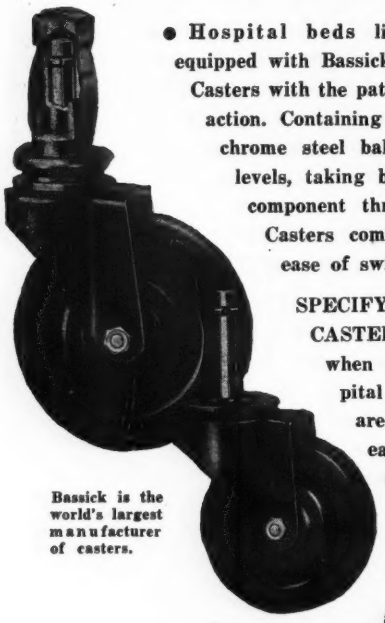
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Across The Desk

Announcing Wax Products, Ltd.

The newly formed Wax Products, Limited, a subsidiary of the Dustbane Products, Limited, 200½ Bank Street, Ottawa, of which C. E. Pickering is president, has begun construction of a steel and concrete fire-proof building on the C.P.R., east of Hurdman's Bridge.

The 12,000 square foot building, with equipment, will cost approximately $50,000, and it is expected that it will begin operation May 1 with 20 employees.

Mr. Pickering heads both companies, and Philip Tetu, secretary-treasurer of Dustbane Products, Limited, will act in the same capacity for the new company.

* * * *

Captain Clarke McGlashan Returns to Firm



Clarke McGlashan, third generation of the McGlashan family with the McGlashan, Clarke Co., Limited, Niagara Falls, manufacturers of Silver Plated Flatware and Table Cutlery, has retired to reserve status in the Canadian Army and again taken up his position as Secretary and Treasurer of the Firm.

Captain McGlashan joined the Army as a private in 1940 and later proceeded to the Officers' Training Centre at Brockville, Ontario, where he was commissioned in the Royal Canadian Ordnance Corps.

Captain McGlashan is looking forward to renewing acquaintances with his many friends and associates in the Trade.

* * * *

Frigidaire to Expand

Plans are completed and construction begun at Leaside for the post-war expansion of Frigidaire Products of Canada Limited involving a three-time increase in production facilities and an expenditure of approximately $2,000,000, it is announced by W. C. Cannon, President and General Manager. Plans include construction of a new power plant and a new porcelain plant and the utilization of three other buildings, now only partly occupied, close to the main plant at Leaside.

When construction and tooling are completed production facilities and employment will be three times pre-war level. There will be a broad line of units for the commercial and institutional market including ice cream freezers, beverage and water coolers, air conditioning units, locker storage plants and refrigerators for meats and other foods, and for special hospital purposes.

* * * *

The suspicious wife of a certain doctor made a visit to his office. She introduced herself to his pretty secretary, adding, "I'm so glad to meet you. My husband has told me so little about you".



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Dominion Metalware Industries Limited will make a specialty of highest quality products. Highly trained metal workers are ready to serve you. Prompt service, good value, fine quality, and courtesy will follow your every enquiry.

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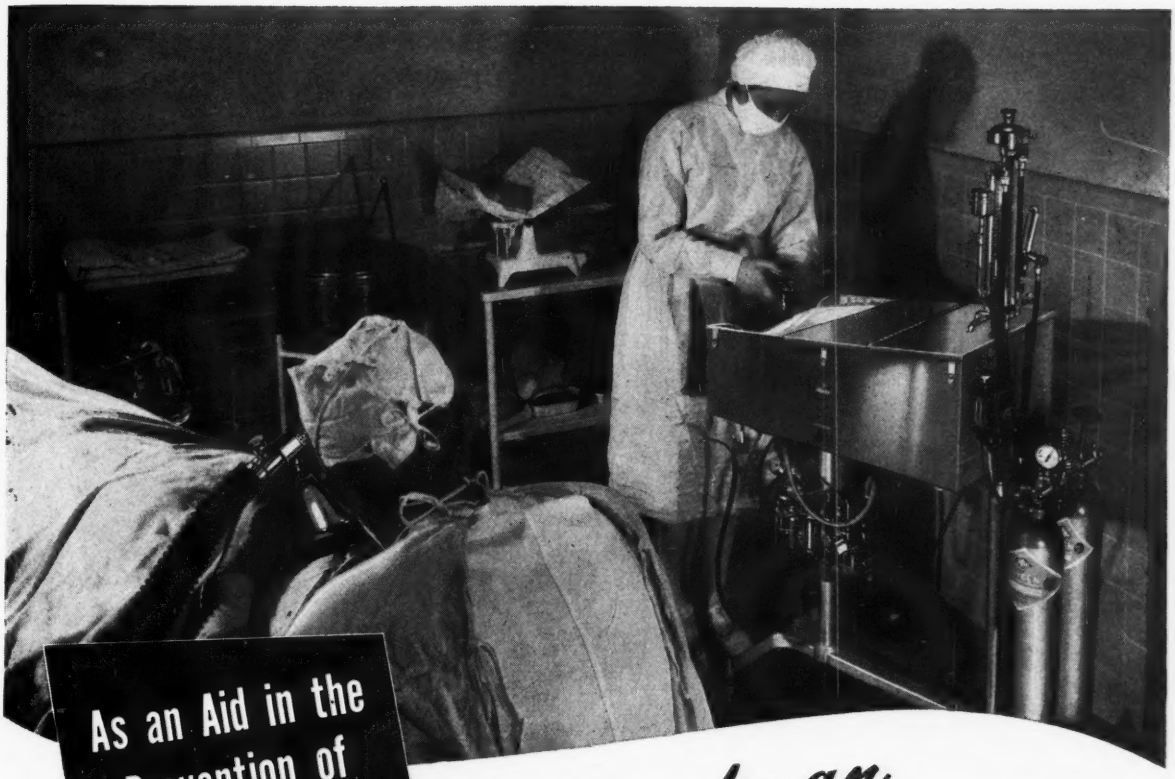
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- Annunciators of All Types
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Included in the Kreiselman line are machines for adults and infants—heated bassinet models and bassinets with head tents.

An informative 20-page booklet just published gives complete details about Kreiselman Resuscitators. This booklet will be supplied upon request, together with a copy of the reprinted article "The Treatment of Asphyxia" by Joseph Kreiselman, M.D., Consultant in Anesthesiology, George Washington University Medical School.

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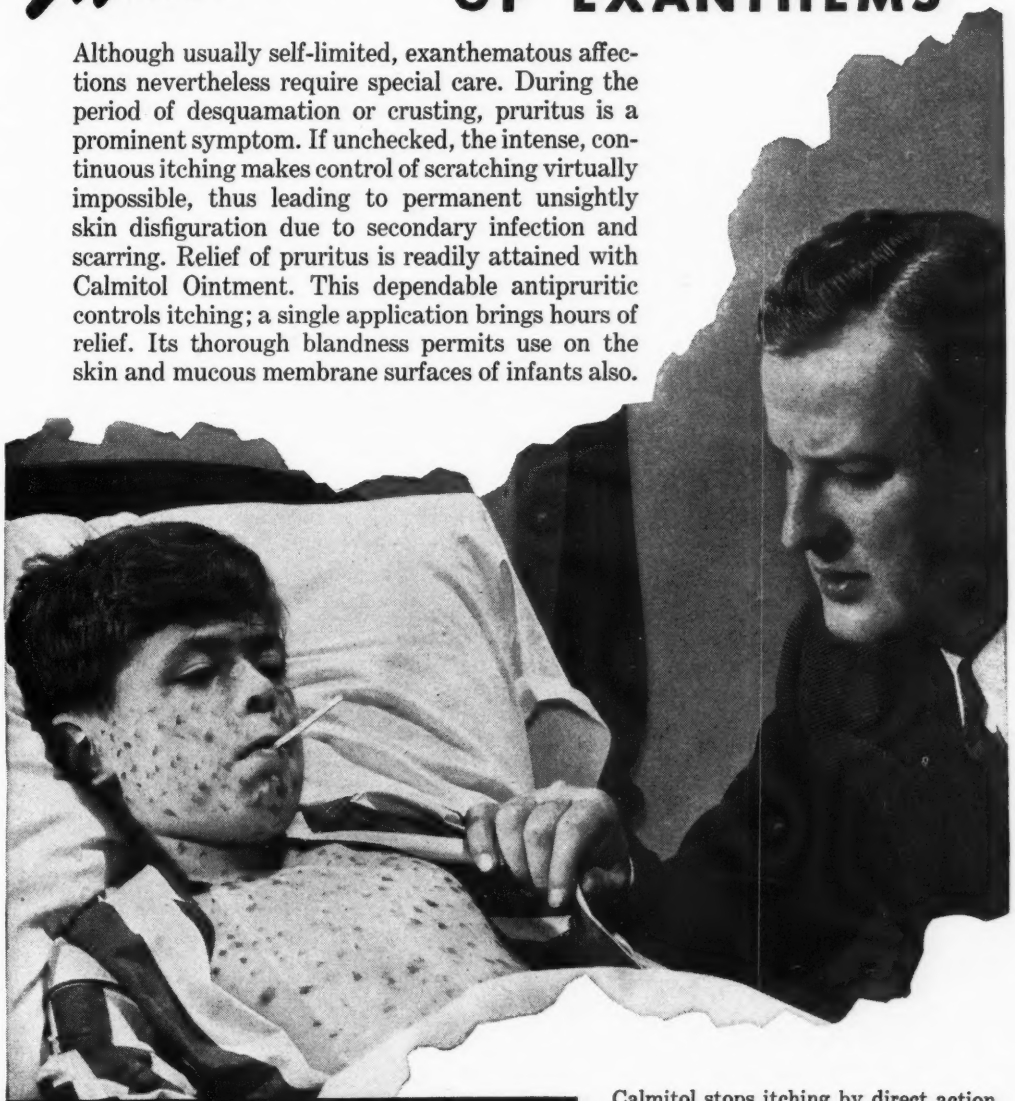
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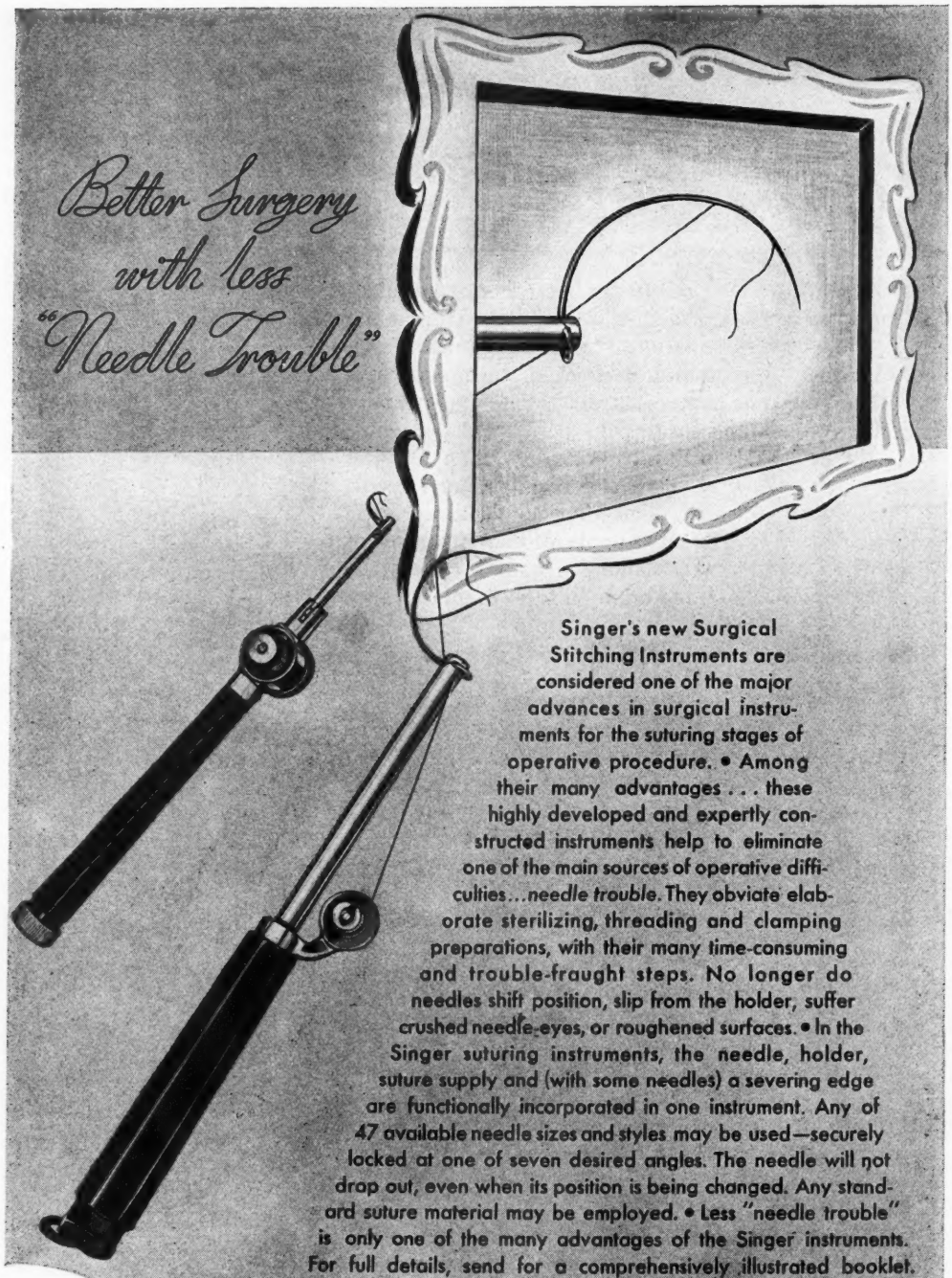
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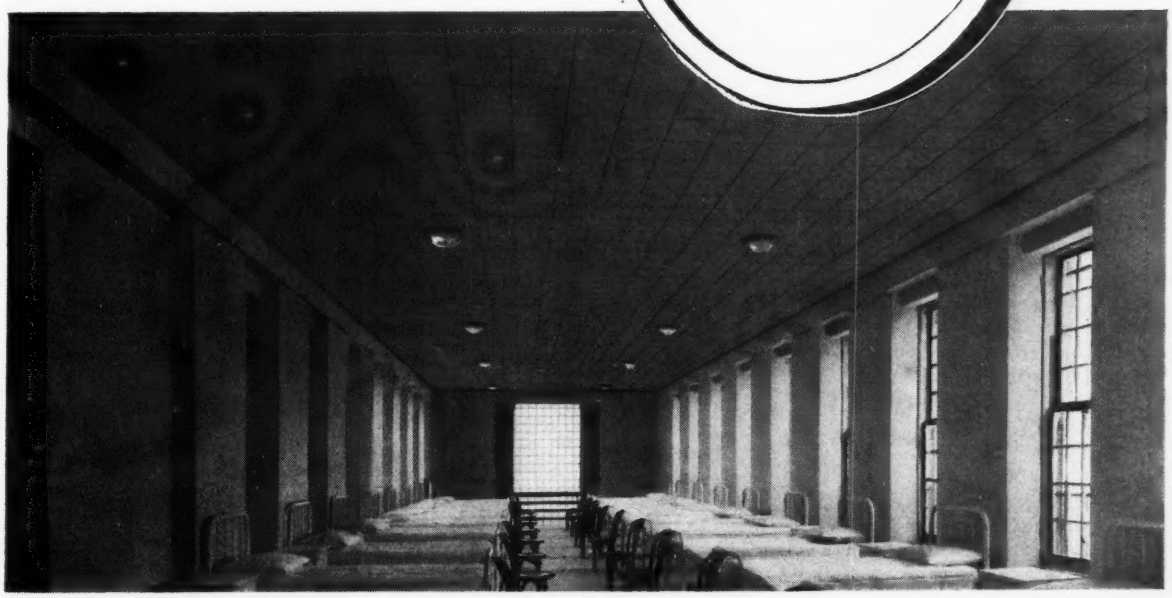
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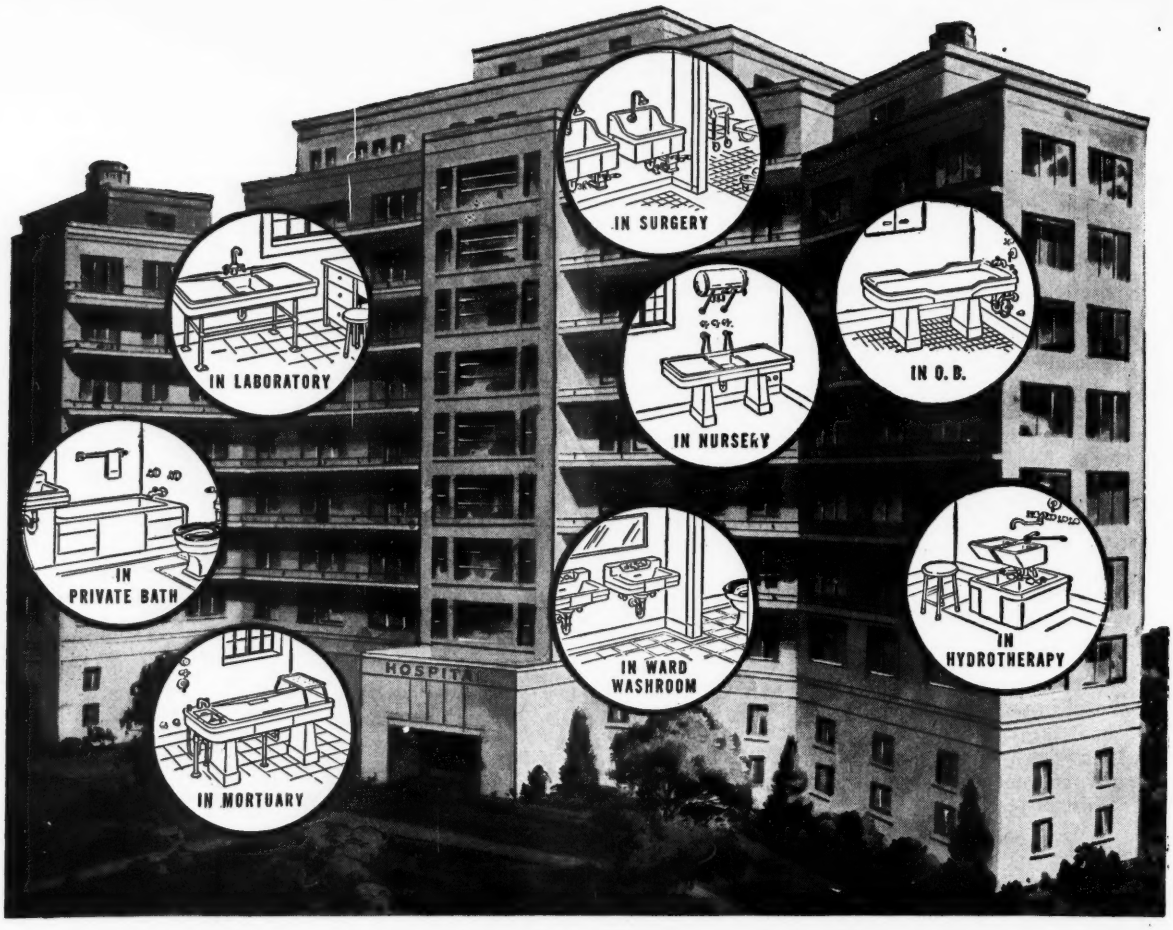
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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, February, 1946 Vol. 23 No. 2

It is the Spirit that Quickeneth

By SISTER MARY GREGORY, S.S.A., M.A., Reg.N.,
Superintendent of Nurses,
St. Joseph's Hospital, Victoria, B.C.

IN practically every field of activity the world over, some measure of the feverish unrest that charterizes the unsettled peace of these post-war days is all too plainly to be felt. It is therefore not surprising that some repercussions may be found reflected even within the ranks of the nursing profession. We live in an age, moreover, in which even zeal for social betterment is impregnated with the materialistic outlook. The nursing services are not free from exposure to the influences of the age. It would probably be a benefit, then, to note in what general direction the wind of discontent is blowing and endeavour to adjust our sails so as not to be diverted from our high vocation as ministers to the sick.

First we may ask, by way of analyzing the problem: Is the nurse of to-day actuated by the true spirit of her noble profession? Do the lofty ideals which first attracted her to spend three long years of diligent, persevering effort in order to acquire the "art" of relieving suffering humanity, still motivate her as with Reg. N. affixed to her name, she applies for her first position? Does the question arise in her mind: "What am I putting into this? What have I to offer for the good of others?" Or, unhappily, does she consider: "What am I getting out of this? What will this position bring to me?"

All of us who are making it our personal concern to forward the interests of nursing know that the answer hidden in the mind of the prospective nurse is really the answer to our questioning, insofar as it supplies the reason for subsequent unrest and dissatisfaction in one case, and contentment and devotedness in the other. The substitution of any other form of motivation for the true spirit or lofty idealism of the true nurse is bound to prove a most formidable barrier in the nurse's pursuit of happiness in her chosen calling—in the pursuit of that happiness that results from the spirit of generous forgetfulness of self in the service of others.

Let us not grow weary of seeing over and over again in Florence Nightingale, the founder of modern nursing as she is called, an embodiment of the ideals towards which any nurse should aspire. True, we have in the history of our own Canadian development, one, Jeanne Mance, who preceded the "Lady of the Lamp" in time, and brought to the care of the sick in Montreal of the seventeenth century all the generosity of heart and skill of hand of her later, more universally known, prototype. Either great soul of charity would suffice as model. But with regard to Florence Nightingale we note that the predominant charac-

Address, 1945 Convention of the British Columbia Hospitals Association in Vancouver.

teristic of her eventful career was her great yearning and desire to be of service to her fellow men. Her personal interests remained secondary. In serving she found the joy that was lasting satisfaction to her generous soul. Her own words confirm this: "I give a quarter of century of service and of European experience when I say that the happiest people, the fondest of their occupation, the most thankful for their lives, are those engaged in nursing."

Looking at the problem from the psychological point of view, every woman is made to find her centre outside herself—in other human beings who are dependent on her loving care. It is this that makes woman the centre of the home, it is this that makes a nurse a heroine in the service of humanity, be it in the home, in the hospital or on the field of battle. Woman is most truly herself when she is utterly forgetful of self, absorbed in those around her, alert to their needs and spending herself without stint for them. In a sense, woman is pioneering to-day as she never pioneered before. To elaborate this point would take more time than I have at my disposal. I think it is clear, however, that, in the confusion and materialism and the economic disorder of our times, problems lie before woman in every field. In the spirit of pioneers, they must be true to the best that is in them—in the home, in the office, in the nursing profession—and must keep their exalted position clear. Pioneering is never easy. Women have cut through great difficulties before. They CAN do so again, but not by letting the disturbing influences of the day carry them into the throes of unrest and leave them stranded on the shores of disappointment and resentment.

It would indeed be sad if, with all our facilities for bringing health to the sick, our advances in professional training and skill, our shorter hours of duty and our recognized position in society as registered nurses, we should fail to verify for our own age and time, the conclusion arrived at by those who pioneered in the field. It would indeed be sad if we should have less care for human life and more for the material goods of recreational ease and increased salary, to the extent that we would barter happiness and the sense of well-doing for the gains that have little lasting value. Edward Leen, noted English author, said recently that never before in the history of the world were there so many material comforts furnished for the people of the world, and yet never was there so great and so widespread dissatisfaction and unhappiness.

Someone will say: but how can a nurse have security through her profession? Her hours are long; her work is heavy, sometimes tedious; her salary is inadequate. These are points with which I have no intention of dealing. However, I can say that if a nurse does her duty—gives the best that is in her for the lives entrusted to her — no remuneration will ever—can ever—repay her. A nurse needs money, surely, and she should have an adequate salary; but if money is her goal there are much easier ways of earning a livelihood than by nursing. It might be said that we should be practical; we have become so practical that we are in serious danger of losing the spirit of nursing and, with it, the happiness of serving an ideal.

If the nurse, unhappily, develops a false sense of values, she will find herself discarding first the spiritual and then seeking satisfaction in material things only. She will sacrifice the contentment that goes with higher striving. Incidentally, it is the satisfaction of realizing that she is of service to others that creates happiness in the life of the religious nurse, whose whole calling means service on a higher plane.

True, the nurse should have the hours of leisure necessary for rest and relaxation, for the pursuit of cultural and social contacts and all that constitutes a full life, but duty sacrificed in the pursuit of any one of these will leave its aftermath of dissatisfaction. One engaged in the high profession of nursing, of preserving the lives of others, cannot stoop to lower levels without loss—loss indeed to those she attempts to serve, but still more loss to herself.

Again Florence Nightingale has remarked: "I fear a nurse who does not pray. Given the opportunity to do much good, such a one may do much harm" and, sadly, the harm is not all to the patient, for the higher, Christ-motivated inspiration is neglected.

It has been my happy privilege, through many years, to be associated with nurses who have helped to build up the standard of the profession in British Columbia. The names of these noble workers may not appear in the headlines, their deeds may not be published, but to them is owing a debt of gratitude mankind could never attempt to repay. These women have been too busy doing things, too happy in working for others, too engrossed in making history to realize how much they were doing to maintain the high standards set by the heroines of nursing history. And they are happy!

Finally, in looking towards her ideal every nurse needs to bear in mind, above all else, the purpose of her existence. She was made to know, to love and to serve her Creator during her earthly pilgrimage that she might attain to an everlasting reward. In what more noble capacity could she accomplish this than in being actively engaged in the alleviation of the sufferings of humanity, bearing in mind the consoling words of the Divine Physician: "Whatsoever you do to these, the least of My brethren, you do it unto ME!" Therefore, I would emphatically say that if a nurse is true to her calling she will never be dissatisfied.

B.C. Aids Organize

Over $67,000 has been raised by the Women's Auxiliaries in British Columbia hospitals during the past year. This was reported by Mrs. A. A. Plummer of Vancouver, who succeeds Mrs. George Darby as president. At this meeting it was finally agreed to have a provincial women's aid association functioning in its own right but closely linked with the B. C. H. A.

Provisional officers are: President, Mrs. A. A. Plummer, Vancouver; 1st vice-president, Mrs. T. R. Selkirk, New Westminster; 2nd vice-president, Mrs. E. Bradish, Chilliwack; 3rd vice-president, Mrs. L.A.C. Panton, Kelowna; 4th vice-president, Mrs. E. W. Neel, Duncan; secretary, Mrs. Lawrence McCulloch.



Chinese Medicine

.... Ancient and Modern

By LESLIE G. KILBORN, M.D., M.A., Ph.D.,
Chengtu, Szechwan, China

Part I
Ancient Medicine

IN this scientific age it is difficult to realize the extent to which men were bound by tradition in the pre-scientific world. It is not very long since the authority of Hippocrates, Galen and Aristotle determined men's thinking in the field of medicine, or since men saw the structure and function of the human body only as they had been taught to see them by the ancient masters. In those days personal observation and experience not only were neglected, but were outlawed as heretical, and men were punished for reporting facts that did not agree with the old beliefs. The advent of science has given us not only increased physical comfort, better health and greater freedom from disease, it has also altered our entire outlook on life. Controlled observation, not philosophical speculation, now determines to a great extent our ideas of man and of his relationship to environment. This does not mean that the ancient sages were wrong on every count. It does mean that we are no longer bound to servile acceptance of everything they taught as the truth, the whole truth and nothing but the truth. We are free to seek new truths and, in the light of what we find, to revise the theories that have come down to us from the great men of old.

Chinese medicine, like that of Europe before the beginning of the scientific era, was determined by her ancient sages. From their early observations and speculations were derived the principles and practices of medicine in China; as we shall see, these did not differ fundamentally from those in vogue in the West until recent times.



Chang Tao-Ling

Sometimes called the Taoist pope, his book on charms was a second-century best seller.

Tao, the Way of Nature

Ancient Chinese medicine is based upon the conviction that man is part and parcel of the universe in which he lives. From the original chaos was evolved the Great Absolute, which in its creative aspect is a metaphysical principle, the Way or the *Tao,* from which all ideas arise. In its material aspect it is primordial matter, out of which the whole material universe, including man, was fashioned. As this primordial matter continued to evolve, it became differentiated into negative and positive phases, the *Yin I* and the *Yang I.* These two are the regulative forces that through their interactions form both the spiritual and the material aspects of the universe, including the soul and body of man. When they are in harmonious balance there is health; any imbalance produces disease.

From the ceaseless interaction of the *Yin I* and the *Yang I* there arose the Sun and Moon, the Fixed Stars and the Planets. The inscrutable, but immutable, law of their unions and disunions is the *Tao,* the Way of Nature, and this is illustrated by eight groups of whole and broken lines known as the *Pa Kua.* The

Dr. Kilborn is Director, College of Medicine and Dentistry, West China Union University and Professor of Physiology. He is a graduate of the University of Toronto.



Shrine of the Three Medical Emperors—Shen Lung, Fu Hsi and Huang Ti.

figure representing the *Yin I* and the *Yang I* and the *Pa Kua* is a potent charm, and when hung above the entrance to a house will protect the occupants from all evil, because it is emblematic of the universe with which they seek to be in harmony. The legendary author of this emblem is the Emperor Fu Hsi, who is said to have lived nearly 5,000 years ago. The universal belief is that the *Pa Kua* was revealed to him while riding on the back of a supernatural animal that rose from from the waters of the Yellow River. It has been in general use for at least 2,000 years to symbolize the processes of nature, and is a feature of all Taoist discussions of philosophy, astrology, divination and medicine.

Continuing further, the *Yin I* and the *Yang I* formed the five elements: metal, wood, water, fire and earth. All matter is constituted of these in balanced proportions. The five viscera correspond to the five elements, metal to the lungs, wood to the liver, water to the kidneys, fire to the heart and earth to the spleen. Any disturbance, therefore, of the delicate balance results in disease.

The theory that health appears as a condition of perfect equilibrium is, of course, very similar to the Greek idea that the four cardinal humours, blood, phlegm, yellow bile and black bile when correctly mingled in proper proportions are responsible for health, and any disharmony in the mixture produces disease. In fact any preponderance of one or the other of these humours makes a definite impress on the personality. We also find in ancient Greek medicine many references to the four elements, three of which correspond with those of the Chinese, and the philosopher Empedocles emphasized a duality of opposing forces, similar to the Chinese *Yin* and *Yang,* which were supposed to be responsible for the control of body equilibrium. The Chinese ideas probably antedated those of the Greeks. Did both come from a common source, or did the philosophical speculations of thinking man develop along similar lines in both Europe and Asia? It is an interesting question. In any case, similar beliefs remained in vogue until the advent of scientific medicine in relatively modern times.

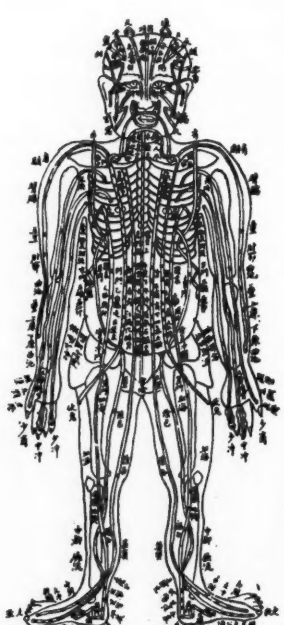


Chart Showing Acupuncture Points.

To return to Chinese medicine, we find that also of great importance are the spirits that form a part of vital essences whose balance results in health. In man are united the lower or animal spirit, the *kuei,* derived from the *Yin I* and the higher or intellectual spirit, the *shen,* derived from the *Yang I.* The soul of man is composed of the *kuei* and the *shen* elements, which are fused at his birth, but which separate again at death, the *shen* ascending to its *Yang* source in heaven, and the Kuei descending to earth, the resting place of the *Yin.* Disease may be caused by the *shen,* or higher soul, temporarily leaving the body. Unless it is enticed back, death will ensue. The souls of young children are especially prone to wander off and get lost, and then the mother may be seen calling the errant spirit to return. Usually she carries with her some article, such as a garment of the ailing child, a lighted candle, or other object. The matter becomes more difficult if the soul has been seized by a malevolent demon, as sometimes happens, for then serious complications are sure to develop.

Thus we find that since two opposing forces, the *Yin* and the *Yang,* permeate all nature, man also has a double nature or soul, composed of antagonistic elements. Any imbalance between these results in mental abnormalities. Dreams, trances, and even sleep, are all illustrations of this duality. During such times the soul wanders free from the body. Even shadows are a part of the soul substance and may not be injured with impunity. One of the first cases I was called to treat after arriving in China was one of mad dog bite of the shadow!

The Nei Ching

This brief summary of the Chinese philosophy of medicine will indicate the system that held sway for about 3,000 years. According to popular belief, it originated over 4,500 years ago, for tradition ascribes the authorship of the *Nei Ching,* or Canon of Medicine to Huang Ti, a legendary ruler who is supposed to have lived from 1698 to 1598, B.C. This book contains the basic ideas held by all subsequent medical men. It is probably of composite authorship, and was likely first written about the second century before Christ. It summed up not only the theoretical

principles but also the anatomical and physiological beliefs of the time, and fixed them in an unchanging pattern for over twenty centuries.

The ideas of anatomy contained in the Nei Ching, and accepted to this day by the practitioners of the native art of medicine, are primitive indeed, and rest upon only casual observation. The internal organs are divided into the five *tsang* and the six *fu*. The former include the heart, liver, spleen, lungs and kidneys, and are supposed to be solid, "storing up but not eliminating". The latter include the gall-bladder, stomach, large intestime, small intestine and *san chiao* or three burning spaces, and these are said to be hollow, "eliminating but not storing". (Where the three burning spaces are located is a matter of some doubt, as no modern anatomist has succeeded in discovering them. This, however, does not discourage the true disciple of Huang Ti, for he puts the authority of the master above the results of human observation.) It is probable that some dissection of the human body was attempted in ancient times, but if so it must have been as casually done as in Europe, for many gross errors are included in the descriptions that have come down to us. For example, the small intestine is said to be attached to the spine behind and to the navel in front. It appears, however, that the ancient Chinese anatomists took great delight in determining physical standards, for detailed measurements are recorded of the size and weight of various organs. For instance, the capacity of the stomach is stated to be 3½ pecks, or 28 quarts. If the ancient units of measure correspond at all with ours, the men of those days must have had prodigious capacities As in Europe, the function of the blood vessels was not clearly appreciated, for they were supposed to carry both blood and air. In fact most of the physiology was a product of the imagination. The heart, for example, was said to be the prince of the body, the seat of the vital spirit. The lungs were the ministers who regulated activity. The liver was the source of strategem. From the gall-bladder emanated courage, and so on. There was no appreciation of the importance of the nervous system, and the brain was classed with bone marrow.



Wayside Dictor's Display of Bones and Charms.

It has been claimed by some enthusiastic persons that the Chinese anticipated Harvey by some twenty centuries in discovering the circulation of the blood. There is no evidence for this, even though the Nei Ching contains such statements as:

"All the blood is under the control of the heart."

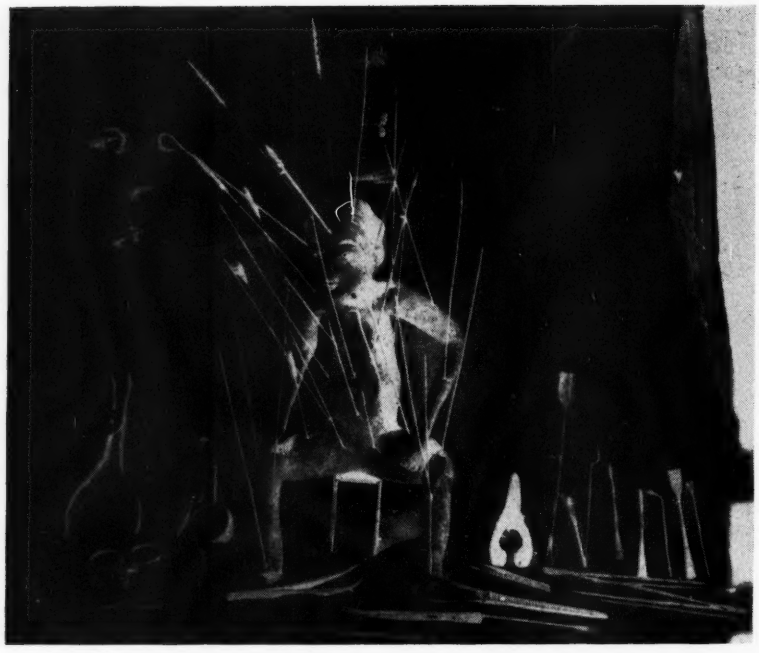
"The blood cannot but flow continuously like the current of a river, or the sun and moon in their orbits. It may be compared to a circle without beginning or end."

From these statements we see that the ancient Chinese did realize the blood flowed, but they had no conception of the pulmonary and systemic circulations. They confused arteries and veins, and they got air as well as blood into the vessels. According to one passage the blood stream is said to start from the foot, and then travel to the kidneys, the heart, the lungs, the liver and the spleen in that order, and then back to the kidneys again, thus making a complete circuit.

As already indicated, health exists when there is a harmonious balance between the *Yin* and the *Yang* principles or humours, and among the five elements. Certain external factors are listed as possible causes of disturbance, such as wind, heat, dryness, moisture, etc. Of these wind is the most important, for when it enters any organ serious results follow. The four seasons are also brought into the picture, so that the perfect equilibrium of health is indeed a complicated matter, in which the *Yin* and the *Yang*, the five elements and the *shen* and *kuei* phases of the soul must be brought not only into an internal balance, but also into harmony with the external environment, which varies of course with climatic factors and with the four seasons. Any departure from this equilibrium results in sickness.

Diagnostic Procedures

Naturally the diagnostic procedures are of great importance, and although the Nei Ching lists four approved methods, observation, listening, questioning and palpation of the pulse, in time the first three were neglected and almost complete reliance was placed upon the pulse alone. It is recorded that Pien Ch'iao, who lived about 225 B.C., was the first exponent of the idea, but most of China's pulse lore dates from Wang Shu-ho, who wrote the Mo Ching, or Pulse Classic, about 280 A.D. The procedure adopted for the examination of the pulse requires that it be felt in three areas on each wrist, called the inch, bar and cubit, and the method of palpation (whether external or internal) reveals the condition of a different organ for each location. Various authorities disagree concerning the relationships between



Early Chinese Doctors Developed Many Special Instruments.

the different pulses and the particular organs. Not only are extravagant claims made for the diagnostic value of the pulse, but it is also relied upon for prognosis, and for such things as revealing the sex of an unborn child. The varieties of the pulse are described in great detail, and no less than 23 are differentiated, such as slippery, empty, wiry, hidden and taut. With 12 pulses, each capable of being described in 23 different ways an almost indefinite number of combinations is possible, and each is supposed to reveal a distinct disease. It is not surprising that authorities differ in some of the details!

Belief in *demon possession* as a cause of disease is also common in China, and hence exorcism is a recognized method of treatment. Probably such practices had an early origin in a remote period, but they were greatly developed under Taoist influence. In the second century A.D. Chang Tao-ling, sometimes called the Taoist pope, wrote a book of charms for the curing of disease and the expelling of demons, and this had a tremendous vogue. These charms might be written on paper, then burned and the ashes applied to the affected part, taken in tea, hot water or wine, etc., or the charm might be carried on the person or pasted on the wall or hung above the entrance to a dwelling.

Elixir of Immortality

The Taoists also sought the elixir of immortality, the equivalent of the Philosopher's Stone for which the alchemists of Europe spent countless years in fruitless search. In fact it is probable that alchemy originated in China, and travelled from there to the West. The search for longevity in China reached its climax in the T'ang Dynasty, 618-906 A.D. Of the 22 rulers of this period seven died from the effects of their self-prepared elixirs, and the time and fortunes of many thousands of persons were spent in the fruitless search for a formula that would yield perpetual youth, wealth and happiness. A host of substances was used in various recipes, and of these a number gradually acquired enormous reputations. Chief among these were cinnabar, gold, jade and pearls, enthusiastically entitled "the essence of Heaven and Earth"; it was said that "he who consumes them, shall terminate his existence simultaneously with Heaven and Earth". Many vegetable products too were considered rich in the vital force which would confer long life upon the person fortunate enough to swallow them. Chief among such plants stood the pine and the cypress, whose seeds and resin were frequent ingredients of the elixir of immortality, for in them was concentrated the soul substance of the tree. Many types of fungi, and the fruit and resin of the peach tree, were also valued as agents of longevity.

The Taoists also introduced certain forms of deep breathing which were supposed to have beneficial effects upon health and to restore youth. For example, it was recommended that one should inhale deeply, count 120 heart beats (!) and then exhale so slowly that a goose feather suspended in front of the nose and mouth would not stir. With practice the number of heart beats counted during a single inhalation might be increased gradually to 1,000! When an old man had attained to such ability he would be transformed into a young man.

The Buddhist religion, introduced from India in the first century A.D., also had considerable influence on the development of medicine in China. Many psychotherapeutic methods were introduced, such as faith healing, hynotism and autosuggestion. The last named was much practised under the name of meditation, and this art sought to develop relaxation and mental repose. Through the long ages of China's troubled history this has been a way of escape from the miseries of the world for many of China's best minds. Unfortunately society thus lost valuable leadership to which it was entitled. For example, the Buddhist saint Bodhidharma was supposed to have sat for nine years with his face to a wall, wrapt in meditation. Buddhism also introduced boxing as a physical exercise. However, the Buddhists, like the Taoists, included evil influences, devils and demons among the causes of disease, and hence they too developed charms and incantations for the expulsion of these unwanted beings. Thus the Buddhist priest took on some of the functions of a physician.

Early Acupuncture

Treatment of disease in China very naturally was in accord with the prevailing theories as to causes. In addition to exorcism by charms and

(Continued on page 68)



A Propos de DISPENSAIRES

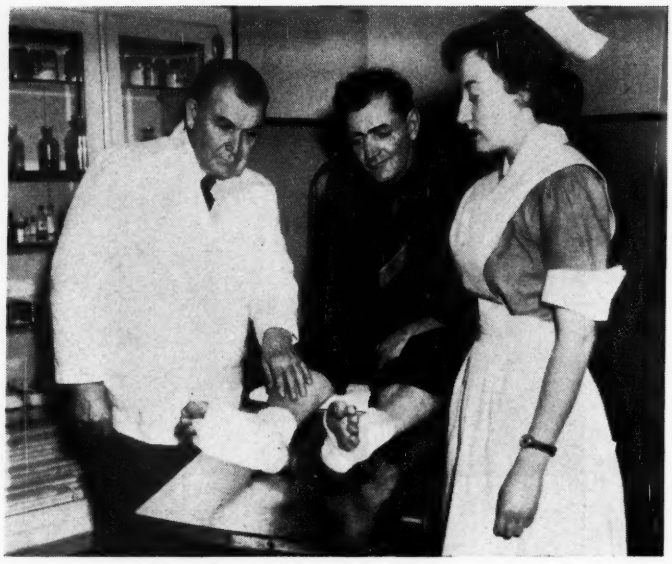
Par ROMEO BOUCHER (F.R.C.P.(C)
Médecin-chef de l'Hôpital Saint-Luc
Professeur titulaire à l'Université de Montréal

ON ne saurait concevoir un hôpital sans dispensaires. D'autre part, un dispensaire ne peut se compléter que par les services que l'hôpital met à sa disposition. D'où vient donc que cette question des dispensaires, dans un hôpital, soit si épineuse et paraisse si touffue? Qu'elle soulève tant de questions, tant de discussions? Loin de moi l'idée de trancher ce différend. Trop de circonstances locales, trop de contingences particulières entrent en jeu pour qu'il soit possible d'en tirer des conclusions définies. On ne saurait, par exemple, envisager sous le même angle, l'hôpital général et l'hôpital spécialisé, l'hôpital général d'une grande ville et l'hôpital général d'une moins grande ville, de celui qu'on est convenu d'appeler un "hôpital de décentralisation". De plus, beaucoup d'administrations travaillent avec trop de moyens différents pour donner une étude d'ensemble de tout le problème. Il vaut mieux le réduire à sa plus simple expression et prendre le cas le plus clair, le dispensaire de l'hôpital général d'une grande ville.

Nous ne sommes plus au siècle de l'empirisme. L'hôpital a pris corps, si je peux dire, dans notre civilisation, au même titre que l'électricité, la mécanique et la radio. Il ne viendrait à personne l'idée de ne jamais se servir, en ville, de la lumière électrique, des tramways ou de l'auto. Il vient de plus en plus à l'idée de chacun de se tourner vers l'hôpital en cas de maladie grave. Au centre d'une ville, c'est le lieu vers lequel tournent les yeux de tous ceux que le mal tourmente. Si le malade est riche ou d'aisance modeste, il a son médecin auquel il confie ses misères sans inquiétude, car il sait que celui-ci n'hésitera pas, s'il en est besoin, de recourir aux moyens que l'hôpital lui offre pour établir un diagnostic et donner à son client la thérapeutique efficace. Mais si le malade est pauvre? S'il est pauvre, le dispensaire est pour lui. Donc, première constatation: le dispensaire est pour celui qui ne peut se payer les soins d'un médecin. Ce qui entraîne une conséquence précise pour l'administration: le dispensaire est une charge et ceux qui le fréquentent ne peuvent ou prou payer. Il faut donc prévoir un local, du personnel, des médecins. Et comme le mot dispensaire vient en droite ligne de l'anglais *dispensary (to dispense,* distribuer), emprunté à son tour, il est vrai, au latin *dispensare* qui,, à l'époque classique, signifiait aussi distribuer, il a bien fallu que dans un dispensaire l'on distribuât quelque chose. Et c'est pourquoi, non seulement on y fait des examens, mais on y donne des conseils, on y distribue des médicaments et on y fait des traitements. Des malins ont bien affirmé que déjà, en 1611, le verbe dispenser s'employait dans le sens de doser en parlant de formules pharmaceutiques ou de laboratoire, mais cela n'a rien à voir avec le propos qui nous occupe.

En haut:
Une partie de la salle d'attente des cliniques externes de l'Hôpital St-Luc de Montréal.

Tout cela serait assez clair s'il y avait dispensaire unique, mais point n'est besoin d'être grand clerc pour comprendre qu'une organisation aussi simpliste se heurterait aux vues de la médecine moderne. Un hôpital n'est pas fait que de murs et d'appareils au milieu desquels se meut un personnel infirmier et ménager. Il y a surtout des malades. Il y a aussi des médecins. Pour que l'hôpital fonctionne à plein rendement, il faut que les uns soient contents des autres et que chacun y trouve son profit. C'est à dessein que j'emploie ce mot qui n'a, sous ma plume, aucun relent pécuniaire. Je veux dire par là que le malade se sent en confiance, que le médecin trouve pâture pour sa curiosité clinique et satisfaction à se dévouer. C'est pourquoi le dispensaire est devenu beaucoup plus complexe qu'on ne le croit réellement.



Un malade pansé dans une des salles du service de chirurgie-externe de l'hôpital.

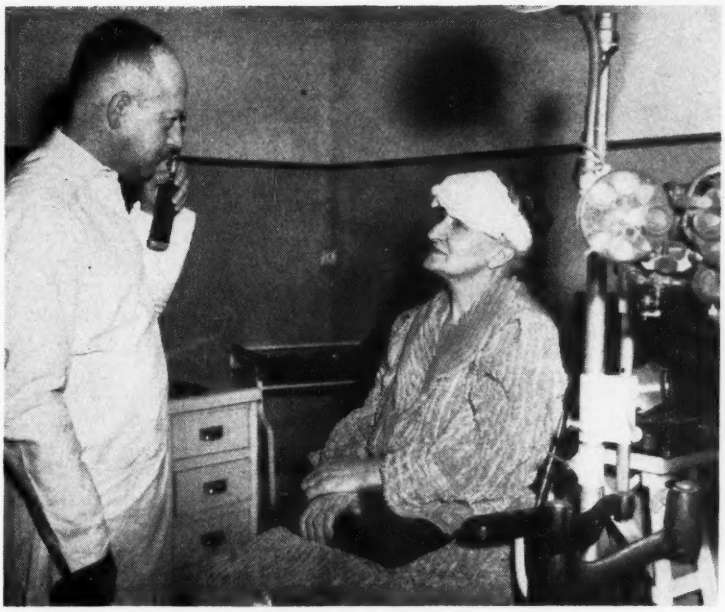
Pour bien faire comprendre le système actuel des dispensaires, examinons les diverses catégories de malades qui viennent s'y inscrire. A l'hôpital il existe des services internes où les malades sont traités selon toutes les règles de l'art et de la science. Ces malades, à un moment donné, quittent l'hôpital les uns guéris, les autres en voie de guérison, les autres en état de mal chronique. Les uns comme les autres ont besoin de surveillance future. Ceux qui ont un médecin régulier lui sont renvoyés et, pour eux, le problème est déjà résolu. Mais les autres? Il faut qu'ils soient suivis, tantôt au point de vue général, tantôt au point de vue spécialisé: yeux, oreilles, gynécologie, etc. etc. . . . Parfois même, il faut prolonger des traitements qui entraineraient un trop long séjour à l'hôpital et une hospitalisation inutile: syphilis, etc. . . . A ceux-là, le dispensaire est nécessaire, impérieux même. Par conséquent, il existe donc entre les services internes et les services externes (ou dispensaires) une collaboration dont le malade tire tout bénéfice. Non seulement le malade, mais aussi le médecin qui peut suivre un traitement commencé, poursuivre jusqu'à la guérison une convalescence amorcée.

D'autres malades, ceux-là venant de l'extérieur, se présentent à l'hôpital pour s'y faire examiner et traiter. Ou bien ils sont gravement malades, ou bien il s'agit d'un cas curieux ou rare que les médecins auraient intérêt à observer longuement. Dans l'un comme dans l'autre cas, le malade est dirigé du service externe au service interne, où il a son lit, son numéro, sa feuille d'observation et subit les investigations cliniques qui orienteront le diagnostic et le traitement. Ou bien alors, le malade n'a pas besoin d'admission, refuse même l'admission, pour des raisons personnelles. Il est alors traité comme un malade du service interne, c'est-à-dire, qu'il subit un examen général, accompagné, s'il est nécessaire, d'examens spécialisés, d'analyses, etc. Il reçoit son régime de vie, son traitement, et revient régulièrement, à date fixée par le médecin traitant.

Enfin reste le malade amené daredare à l'hôpital: accident de rue, pauvre miséreux, pauvre misérable, maladie subite, paralysie, angine de poitrine, etc., accidenté du travail. L'urgence quoi! La plupart de ces malades sont hospitalisés. Les autres y subissent le traitement d'urgence, les examens néessaires et sont ramenés chez eux avec la promesse d'appeler leur médecin ou, s'ils sont pauvres, de venir montrer leurs pansements ou leurs blessures.

Cette question des dispensaires est très complexe. Elle exige un service externe aussi complet, pourrait-on dire, qu'un service interne. Service externe de médecine générale et de ses spécialités, de chirurgie générale et de ses spécialités, de petite chirurgie, d'odontologie et le service des urgences. Sans compter que tous les services sont réquisitionnés: laboratoires, Rayons X, physiothérapie, etc.

Et que dire de la pharmacie? Elle doit répondre aux exigences du service interne et externe. Pensez que dans certains hôpitaux on remplit plus de 200,000 prescriptions par année! Comme la plupart des malades de dispensaires sont pauvres et ne peuvent pas ou que très peu payer, il n'est pas étonnant que le problème des dispensaires soit pour l'administration une question—dans le sens de supplice—de tous les jours. De plus, les dispensaires ne peuvent se faire simultanément. Les principaux, oui; mais les spécialités, par exemple, se font à des heures qui ne correspondent pas toujours aux heures d'activité externe. Les médecins-spécialistes ont à coeur, la plupart du temps, de faire eux-mêmes leur dispensaire à cause de l'intérêt scientifique qu'il leur procure. Comme ils sont souvent requis dans les services internes, cela complique d'autant l'horaire. Et pour tous ces dispensaires, pour tous ces médecins, il faut des aides, des gardes-malades, des infirmiers, des ménagères, des locaux à préparer puis à nettoyer, des appareils à faire fonctionner, des instruments à stériliser, des prélèvements à faire et à envoyer au laboratoire, des dossiers



L'examen d'une malade du service externe d'Oto-rhino-laryngologie de l'Hôpital St-Luc.

à écrire ou à relever, des prescriptions à remplir, des médicaments à fournier, des formulaires à préparer, des techniques à appliquer, des thérapeutiques à continuer, des petites interventions à faire et l'interminable paperasserie gouvernementale à remplir soigneusement pour tout ce qui relève du domaine public.

Et derrière tout cela, l'administration. L'Administration qui doit pourvoir à tout le matériel roulant, piquant, brûlant, éclairant, anesthésiant, ou autre; qui doit canaliser les efforts de tous ces gens qui viennent, les uns pour soulager l'amertume de leur misère, les autres pour comprendre jusqu'à quel degré ces misères peuvent avoir d'amertume, pendant que gravite autour de cet axe: malades-médecins, tout un peuple de serviteurs et de gardes-malades!

Les médecins ne pensent pas assez qu'ils sont l'un des rouages de ce mécanisme nécessaire et utile qui s'appalle le dispensaire; que ce mécanisme a un jeu extrêmement compliqué et que le rôle de l'administration n'est pas de tout repos. Le public surtout, qui se croit tout permis, qui *"exige"* sans donner bien peu de lui-même, devrait être éduqué et instruit de ces *faits*. Il parviendrait peut-être un jour à comprendre que la charité n'est pas faite que de bonne volonté, mais demande, pour être bien ordonnée, une administration minutieuse et une organisation pouvant répondre à toutes les exigences de la vie moderne.

Resumé

Imagine the difficult situation of a general hospital without the services of an out-patient department! But, if there must be a dispensary, if you may call it so, it must function as a facility for ambulatory patients who apply for free treatment or at a very negligible compensation. It must also be considered as an introductory ward for admitting purposes and must also serve the needs of discharged patients who must return to it for further medical observation. To comply with this broad demand, the dispensary will require a medical and non-medical staff involving an extensive department of pharmacy and lay personnel. The above complexity will serve to demonstrate the handicap the administration will find in overseeing such a dispensary.

It is essential that facts relating to the function of the out-patient department should be kept before the public, a public known for its scruples with respect to service, but also known for its lack of co-operation when it gives so little but in turn requires so much from a hospital.

Building and Teaching Programme at Ottawa Civic

A building programme costing approximately a million dollars to meet increased demands on the Ottawa Civic Hospital was forecast by E. Norman Smith, chairman of the Board, at the annual meeting in January. "Our main tribulations all stem from three causes—an overcrowded hospital, a shortage of staff and inadequate space for the important work of technicians and their equipment."

Dr. Douglas Piercey, superintendent, reported all records broken during 1945, despite a reduced nursing staff. In the X-ray and pathology departments the situation was desperate owing to shortage of space. Highest patient census in 1945 was 906, the average being 759, as compared to 662 in 1944.

Under a special agreement Queen's University will send one half of its final year medical students to the Ottawa Civic Hospital for ward and laboratory instruction, stated Dr. C. W. Kelley, secretary of the Medical Advisory Board. This arrangement will commence in 1949. In addition there will be post-graduate courses leading to certification in medicine, in surgery and in obstetrics and gynecology.

Dr. Kelley noted also that many members of the medical staff are showing signs of very severe fatigue. "This is the direct result of heavy professional duties during the war years." Many Ottawa doctors had enlisted and no new ones had come in during the past few years.

New X-Ray Department Grace Hospital, Ottawa

A new radiological department has been opened at Grace Hospital in Ottawa. This hospital caters especially to surgical and obstetrical work and the new equipment will be under the direction of Dr. A. M. McNabb. Part of the fund was raised by subscription and part donated by the Board of Directors of the old Protestant Children's Hospital.

Brigadier Chris Sparks presided and guest speaker was Lieut.-Colonel M. Junker of Montreal, Salvation Army officer in charge of that area. Other participants were Mrs. John H. Garland, Mrs. W. E. Perrin, W. T. Haughton, K.C., the Rev. H. S. Clugston and Mrs. J. W. Gilchrist.

All Graduate Nurses *have a* Teaching Responsibility

By LOUISE D. ACTON, Reg. N.,
Superintendent of Nurses, Kingston General Hospital

BEFORE formulating any of the aims of nursing education, one would like first to enumerate some of the qualities necessary in a nurse, and also mention the main objectives in nursing. Knowing these it is easier to understand the aims which should be the guiding star of the education of the nurse in training.

The primary purpose of the nurse throughout the ages has been and is the care of the patient, and in this we emphasize the mental and emotional as well as the physical care. Nursing has a three-fold objective:

1. Teaching of health, both mental and physical.
2. Prevention of disease.
3. Care of the sick and restoration to health.

Qualities of a Nurse

The qualities of a nurse must be such that she will be fitted to undertake this important and far-reaching work. Just what are these qualities. The following, perhaps, are among the most important:

She should possess good physical health and a pleasing appearance. All patients are impressed by a nurse who is obviously healthy and strong and whose appearance gives evidence of good grooming. The slouchy, untidy nurse does not convey the same impression of efficiency.

She should be emotionally stable and have a professional dignity of manner. This induces a feeling of confidence.

She should have sympathy with, and understanding of, the patient and her problems.

She should appreciate and cultivate a high standard of professional conduct, both in and out of the hospital.

She should be very conscientious and implicitly obedient and should endeavour to possess such nursing qualities as skill, resourcefulness, cheerfulness, kindness, gentleness, thoughtfulness, firmness, patience, tolerance, adaptability, tact and foresight.

She should acquire knowledge, so that she is able to observe, recognize and interpret intelligently the physical, mental and emotional manifestations of health and illness.

Aims in Nurse Education

If the nurses graduating from our schools are to possess the qualities I have just enumerated, we must have some very definite aims in their education. True education improves the fibre, moral and intellectual, of a nurse and creates a healthy mental satisfaction by enabling her to realize worthy aspirations otherwise unattainable. The chief aims, therefore, of nursing education should be:



Louise D. Acton, Reg.N.

1. To stress those principles which assist in the fullest *personal, social and professional development of the individual.* For instance, the young probationer frequently has not had the advantage of teaching in some of the accepted social amenities so necessary to the successful nurse. She may speak loudly, forget to knock at a door; she may wear unsuitable clothes, or not be as neat and tidy as she should be; she will improve if she is in contact with the right type of graduate nurse and if the guidance given is good.

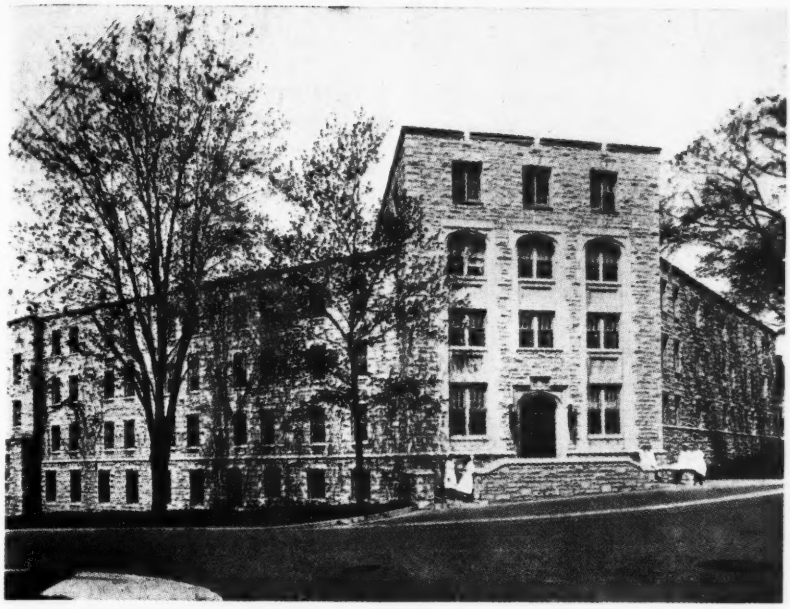
2. *To stimulate the nurse to be a "thinking" as well as a "doing" person.* It is very important that all nurses be educated to think first. They should think of the effect, both mental and physical, that a treatment will have on a patient. By tactful and thoughtful preparation the patient will lose much of the fear of a treatment and will respond better physically.

By thinking first, the nurse's preparations will be more adequate, there will be less waste of time, there will be keener observation and, above all, there will be fewer errors.

To acomplish this end she must be provided with opportunities for self-activity in problem-solving situations, so that she may develop initiative, resourcefulness, good judgment, self-confidence and independence.

3. To foster in the student the *professional ideals and attitudes* that nursing implies. Do we, for example, train the student into good professional channels. For instance, are we ourselves careful not to discuss one patient with another? Are we careful in our methods of addressing the students? Do we show them a good example in our attitude towards the medical profession or do we criticize one to another?

4. To stimulate the nurse *to view a patient as an entity and not in part.* Do we encourage her to think about everything in connection with a patient? Is she encouraged to know, and stimulated to question, what is the



Nurses' Residence, Kingston General Hospital.

matter with the patient? Why the medicine is used and its effect? Why treatments are given?

This is very important, especially where the efficiency method is used in a hospital. If a nurse does only one piece of work for many patients she is apt to lose sight of the patient as a whole—she thinks only in terms of the particular piece of work she carries out, e.g., taking the temperatures or giving the medicines.

5. To encourage the nurse *to broaden their vision and their interests* so that they will be able to meet their intelligent patients on an intellectual footing, and not be dependent on the talking of "shop" to patients or friends. Music, art, literature, religion, sports, current events — all offer a wide field of interest. Pursuing one or more of these interests as a hobby prevents the narrow one-track mindedness so often found among nurses, and helps in developing an interesting and more rounded personality.

6. We should also aim to assist in the personal and professional development of the student by *making the clinical programme on the wards as wide as possible.* So frequently there is an over-emphasis on routine work and the repetition of a few procedures. Do we endeavour to give every nurse as wide and as varied and interesting an experience as is possible on each ward, or do we keep one nurse doing the same piece of work just because she does it well? Frequent, repetition is *not* an educational factor—it is only necessary in the development of some of the skills, and even then it must be done thoughtfully.

7. We should aim, from the first day the student is in training, to *build up in her mind the idea of the nurse as a teacher, and expect her to develop that idea throughout her training days.* All nurses must teach, but this need not necessarily be formal teaching. We should understand that our example in all we do in the hospital as well as our informal talks and demonstrations are all ways of teaching the students, and that they, in turn, teach the more junior students and their patients by the work they do.

8. Lastly we should aim at the development in the student of a *critical attitude to her work* to stimulate in her a keenness and awareness, or imagination-stirring, that will create a great desire for improvement. Much satisfaction will follow from work well done. Constructive criticism by others is always helpful, but all nurses should be encouraged to view a situation *objectively.* To do this they should have the correct theoretical scientific knowledge of a procedure and be able to apply the accompanying five-point criterium as a guide in evaluating their work (see Fig. 1). This criterium should also be used by head nurses, supervisors and instructors when evaluating a practical procedure.

Principles of Learning and Teaching

The basis of all learning is *self-activity.* The learner must take an active part and the more self-directed, the more effective the learning. There must be a strong motivation for learning. The student must *want* and *need* to learn. She must see the values of possible achievement. She must also have a strong interest. The greater the interest, the greater the effort—*interest, wants* and *needs* are constantly changing and hence the learner is stimulated to continue to learn.

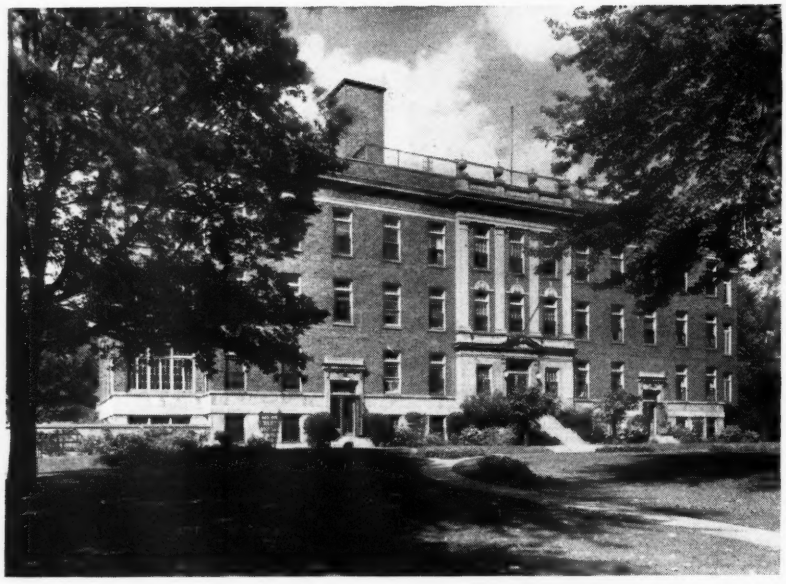
Satisfaction—and also dissatisfaction—are motivating forces in learning. Either one or the other may be a stimulus to further effort. The nurse should be stimulated to develop a feeling of satisfaction from any sucess she attains and she should be guided in her response to failure. If handled in the right manner, a failure may be used to stimulate a learner to greater effort. Great care should be taken that it is not made a cause of discouragement, producing retardation.

It is important for a teacher to remember that the learner reacts as a whole to any situation. While apparently being taught one thing, the learner is subconsciously learning many things. For instance the teacher may convey, unwittingly, undesirable attitudes, likes and dislikes, or mannerisms, which are learned by the student; these sometimes produce many unwanted personality characteristics.

To develop progressive learning there should be practice with improvement. Skills must be practised as soon as possible after the demonstration, and each time one is repeated there should be a determined effort at improvement. This implies the need for *continuous teaching and supervision.* This is also very necessary to develop the individual growth of the student. There should be a sympathetic and co-operative relationship between the teacher, supervisor and student.

All teaching and supervision should be based on the needs, capacities and individual differences of the students. If properly guided the

(Continued on page 86)



Children's Hospital at London Plans Further Expansion

L. J. CROZIER, B.A., M.D., C.M., Victoria Hospital and War Memorial Children's Hospital, London.

THE War Memorial Children's Hospital in London is situated in the same block as the Medical School of the University of Western Ontario and directly opposite Victoria Hospital, to which it is connected by a tunnel. It is owned by the City of London and is administered by the Board of Trustees of Victoria Hospital.

In November 1921 the corner stone of the present building was laid. The planning and erection of the building was brought about by a group of women who later became known as the Women's Committee of the War Memorial Children's Hospital and have continued to take an increasing interest in the work of the hospital. The building, erected as a memorial to the fallen in World War I, is four storeys high and has accommodation, both ward and private, for eighty children. In addition there are ten bassinettes and special facilities for the care of premature infants. A large roof garden, reached by elevator, accommodates beds and cots, allowing fresh air and sun treatments during the summer.

It is a complete and well equipped hospital. The physiotherapy department has a swimming tank which is in use daily in the treatment of poliomyelitis paralysis and other orthopaedic cases. The outpatient clinics in orthopaedics and Child Welfare are large. From the date of its opening in 1922 to the end of 1945, 32,200 children have been admitted as in-patients. During the year 1945 two thousand infants and children were admitted, exclusive of eye cases and communicable diseases, which are treated in Victoria Hospital.

The hospital is well staffed by specialists in children's diseases. The close affiliation with the larger general hospital supplements special facilities. In addition the staff of Victoria Hospital assist in the work.

As well as the ordinary diseases of infants and children, difficult and unusual cases are brought to the hospital, not only from London but from all of Western Ontario. Club feet and other deformities receive the benefits of modern surgery. Accidents and burns are cared for with outstanding results. During the past three years several patients have been admitted with influenzal meningitis, and have completely recovered.

Medical students at the nearby University receive instruction in paediatrics, and fifty-five beds are available for clinical teaching. Interns and student nurses rotate through the various services. Several doctors are now enrolled for post-graduate training. With the increase in population in London during the past twenty-five years and the keen interest shown by citizens, service clubs and other organizations throughout Western Ontario, admissions to the hospital have increased each year. Medicine, too, has advanced during the same period; many facilities must be improved and new ones added in order that the hospital can continue to render the service expected and to receive all children in need of care.

Medical men and citizens of London are greatly interested in the possibilities of this hospital. The Women's Committee, many of the original members of which have been active since 1921, at their meeting in November 1945 passed the following resolution:

"The Women's Committee of the War Memorial Children's Hospital recommend that, recognizing the need for greater and better facilities at the hospital, and in view of the fact that consideration is being given by the City Council to a suitable civic memorial to the Heroes of World War II, such memorial be in the form of a new wing to the Children's Hospital to provide adequate accommodation and that, in the opinion of this Committee, would be most fitting, since it contributes so much to the welfare of the future citizens for whom their sacrifice was made."

The Board of Trustees have passed favourably on the Resolution, and it is now being studied by the municipal officials.

Re-conditioning of the present building and an added wing will give London a splendid children's hospital. Larger and more modern kitchens and formula rooms with the latest equipment will replace the present installations. A more spacious and adequate physiotherapy department with a larger swimming pool, a large-up-to-date splint department and facilities for occupational therapy will be added. The whole of the present first floor will be changed to offices for administration, supervisors and nurses, secretaries, social service

(See next page) ➔

Foods . . . Fancies . . . Frauds . . . and FACTS

By M. EDYTHE PATTERSON,
Chief Dietitian, Public General Hospital, Chatham, Ont.

"THE science of nutrition" is confusing to many people. The word "nutrition" conveys different ideas. Many people think that it is largely concerned with vitamin capsules and mineral pills. Others think nutrition applies only to the care and feeding of children. Still others associate the word with a green, grassy type of menu. The simple fact of the matter is just this: nutrition means good food—protective food—and plenty of it for every man, woman and child.

What retards the spread of this knowledge of nutrition and why is the public so reluctant to accept it? We may put new facts in our minds, but we go right on putting the wrong foods into our stomachs. We must stress the quality as well as the quantity of food necessary for good health. The causes of malnutrition which are known to exist in Canada may probably be classified as *economic, educational* and *indifference.* We have long prided ourselves on being one of the best fed nations of the world, but we realized when the men were called up for defence training that poor diets and malnutrition were common in Canada. We have no food to waste, and we must use the food available to the best possible advantage.

"You cannot eat nutrition." But you *can* learn about it and work at it. It is natural to have a few healthy dislikes, but one should be able to value the fundamental teachings of good nutrition. There are many fads and fancies pertaining to food and food habits. One frequently hears such comments as: "I never take breakfast." "No breakfast cereals for me." "I just cannot drink milk in any form." "Please do not serve me eggs or milk." "No citrus fruits and no tomato juice." "Just serve meat and potatoes—no vegetables." Nourishing foods, protective foods and balanced meals should be a golden rule.

A large percentage of the family income is spent on food supplies. The art of preparing and preserving their nutritious value requires careful thought and organized planning. Through carelessness and lack of good management many dollars are wasted, with resultant ill health and disease. *"Frauds and fancies"* are as common as *"Foods and fancies".* How many times have you stopped to read the colourful, attractive signs, such as: "Are you tired, nervous, no pep?" "Are you getting enough vitamins?" "Vitamins for victory." "You may be a victim of hidden hunger." Vitamins are wonderful for those who need them—the question is, *who need them?* It boils down to this—nutritionists acknowledge that we, as a nation, need more food and better food habits, and an educational programme is needed to inform the public in the careful selection and proper preparation of food—not pills to compensate for the lack of both.

Can we make good food and good cooking as glamorous to the public as the sale of vitamin concentrates? I think we can if we are sufficiently interested, if we have a vision of what we want to accomplish, and if we work at our task.

The "diet faddist" is usually the keep-slim type. "I never eat potatoes or bread"—"Milk adds to my weight"—"Did you every try the fourteen-day diet?"—"I have commenced the buttermilk-and-banana diet"—all with the result that eventually a doctor is consulted and a well-balanced diet is prescribed.

The word "allergy" has assumed a very prominent place in our vocabulary. A person with a food allergy is usually perfectly normal, and when he avoids the substance which distresses him, he is healthy. The remedy is simple enough — keep away from the offending substances.

In the culinary arts department of a hospital you will find a storehouse of knowledge respecting foods and fancies. Our thoughts turn to this great institution with its manifold organization of medical, surgical, nursing and varied special services. From the dietary department must come three meals daily, plus special diets at irregular hours, and these are our chief concern three hundred and sixty-five days a year.

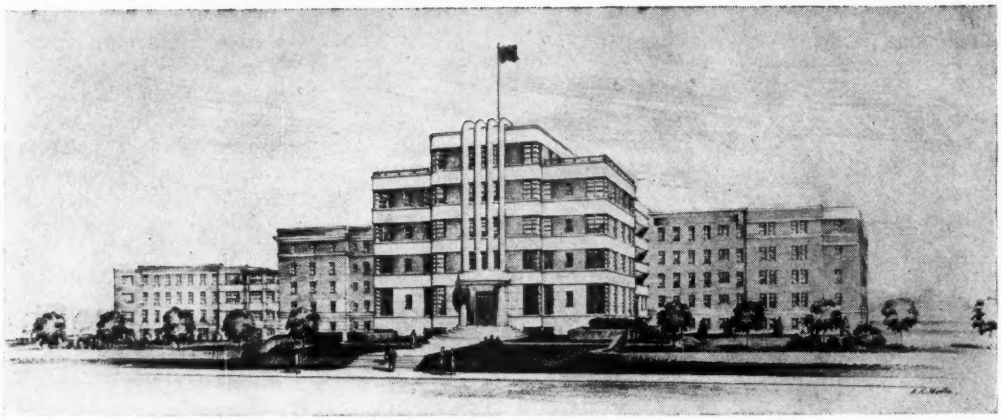
The feeding of the patient, who is really our guest while in hospital, is our task. Many questions may arise in the mind of this special guest. He

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workers, waiting rooms, doctor's room, school room and space for an additional elevator. The new addition will be planned to include a small theatre where children can see suitable movies, where parents may receive instruction in the care of the convalescent patient in the home and more attention can be given the education of disabled children. In addition to the present orthopaedic and well-baby clinics, adequate provision will be made for mental health, hearing, eye and cardiac clinics. An additional 50 beds is required to keep pace with our rapidly-growing needs.

The present hospital now stands as a memorial to the fallen of the First World War. The plans of expansion when completed will not only be a memorial to the fallen in two Wars, but will serve in a practical and constructive way a growing medical and hospital centre. Finally, it will give new generations new visions, a greater appreciation of health and new skills in the treatment of children's illnesses.



Toronto East General to Build Again.

The Toronto East General Hospital is now planning still another addition to the hospital. This will be located on the west side of the hospital and will create a new front entrance.

may not understand the different medical and surgical treatments or know the value of drug therapy—but one subject which he does understand and feels competent to discuss is food.

"Did you enjoy your meals while in hospital?"

"Was the food served hot?"

"How is the tea and coffee?"

So the conversation goes, in the patient's room and long after he leaves hospital. Many patients receive their tray with anticipation and pleasant surprise; others, from lack of appetite or indifference, have little or no desire for food. A few prefer hot foods to cold; salads and sandwiches to regular dinner or supper menus. However, an attractively arranged tray with suitable china and appointments and properly selected and prepared food suitable to the patient's needs, will generally be acceptable.

A patient's diet while in hospital, like other parts of the treatment, is prescribed by the attending physician. To ensure progressive recovery and quick convalescence, the patient must understand, co-operate and be in accord with the prescribed diet.

A Suggestion

The feeding of the patient is the responsibility of the nurse who is caring for him and the dietitian who selects foods according to the diet prescribed by the physician. Here is an opportunity for the nurse and dietitian to use the power of suggestion:

> **"The patient is ill and has little desire for food. The tray has been served, sometimes without comment by the nurse, and perhaps removed without the patient so much as tasting the tempting morsels so carefully prepared and attractively served.**
>
> ***The patient must have nourishment. Food is essential to recovery.***
>
> **Will the nurse be satisfied with recording "Tray refused" and do nothing further? Surely not."**

A few simple suggestions may have some effect . . .

"What an attractive tray!" "Will you taste this? I know you will enjoy it." "What a tempting looking dessert." "I am sure you will feel stronger if you take just a little nourishment." "This is a surprise for you."

After all, adults are but grown-up children and will usually respond to interest and thoughtful care. It takes only a moment to emphasize how essential it is to take food to speed the recovery of good health. You also have a more satisfied and contented patient.

It is a challenge to all nurses, to dietitians and to the public in general: learn the meaning of *good food* and *good cooking.*

Judge N. R. MacArthur

In the death of Judge N. R. MacArthur, Sydney, N.S., County Court Judge of Cape Breton, Maritime hospitals in general, and the hospitals of the Cape Breton area in particular lost an invaluable friend and adviser.

Always ready to lend his assistance to any worthwhile cause, the social and community interests served by the hospitals enlisted his most splendid aid. He was a keen student of hospital needs and always deeply interested in all that pertained to improved services for the community.

He served as legal adviser to St. Joseph's Hospital Board, Glace Bay, N.S., from 1918 to 1922 and during the four years previous to his death proved himself an excellent member of St. Rita's Hospital Board of Management, Sydney, N.S., acting as Provincial Government representative.

His advice was frequently sought and as cheerfully and as wisely given. His fellow associates in hospital direction respected his judgment, as they valued his friendship. His place in the life of the community will be difficult to fill. The hospitals that he served are better for his generous service, itself an example to be followed by all connected with hospital service. *The Rev. J. B. Nearing.*

Can the Voluntary Hospital *be fitted into the* Municipal Hospital Plan?

By A. SOMERVILLE, M.D.,
Medical Inspector of Hospitals, and

E. E. MAXWELL,
Supervisor of Municipal Hospitals, Province of Alberta

Is this an answer for rural areas? Can municipal contracts be made with voluntary hospitals — and with lower taxes and less headache?

FOR a number of years now the municipal hospital idea has been expanding rapidly in Alberta. This expansion has now reached the stage where established hospitals are feeling the pressure of encroachment on their territory or are feeling the pressure of public opinion demanding hospitalization on an insurance basis. Is there a solution which would preserve the voluntary hospital and at the same time meet this desire for further municipal control?

The Alberta Municipal Hospital Act provides for this contingency by authorizing a municipal hospital district to enter into an agreement with an established hospital to provide service to the residents of the area. It is the usual procedure for the Municipal Hospital Board to build and operate their own hospital, but it is quite in order for them to make a deal with any hospital to provide service. This has been done on three occasions recently and other districts are contemplating the same move.

The procedure is the same as for the establishment of an ordinary municipal hospital district. An area is outlined at the request of the municipal councils concerned or on a petition from 25 per cent of the ratepayers. The area may be any shape and does not necessarily follow the municipal boundaries. The area is then established by an order of the Minister of Health and a Provisional Board is appointed. This board draws up a "scheme" in which the proposals for hospital service are outlined and published and a vote is taken which requires a 65 per cent majority in favour before the "scheme" is put into effect. If it is proposed to obtain service from a previously established hospital the terms of the agreement with the hospital are published as part of the "scheme".

Contracts with Sisters' Hospitals

Three hospital districts have been set up in this way at Vegreville, (95 beds) St. Paul (51 beds) and Castor (32 beds). There were slight differences in detail but in general the agreements were similar. Each hospital is operated by one of the Roman Catholic Orders; they supply the building, equipment and service. The Board of the Municipal Hospital District collects the necessary funds through taxation or by the sale of service tickets to non-taxpayers and pays the hospital for services rendered on a per diem basis. In each of the above three agreements the hospital receives for each patient day:

Municipal Hospital Board	$1.85
From the patient	1.00
Provincial Hospital Grant	.45
	$3.30

The hospital is taking a chance on the collection of the $1.00 per day



Vegreville General Hospital.

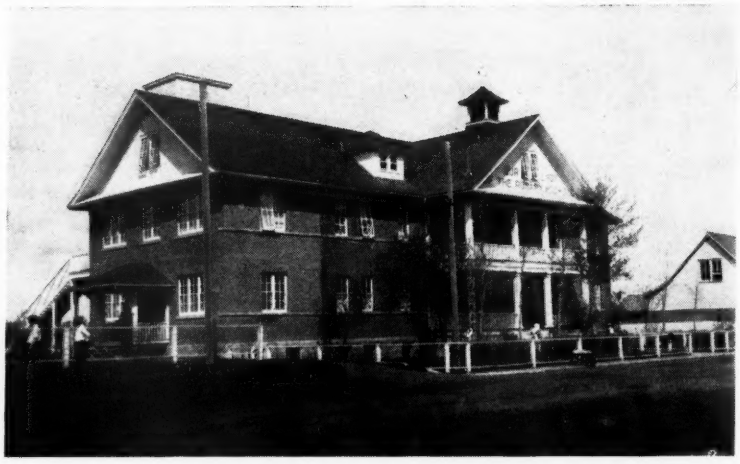
One of three rural Sisters' hospitals in Alberta which operate under the Alberta Municipal Hospital Act.



Left—
St. Theresa Hospital, St. Paul.
Below—
Our Lady of the Rosary Hospital, Castor.
Both of these hospitals have similar contracts.

but since it is a small item it is usually collected.

Discussion as to the merits of the two systems has revolved around the problem of the ownership of the hospital. To the authors this appears to be of minor importance. In an ordinary municipal hospital a higher tax is paid to provide a sum for the eventual payment of the debenture debt. When those payments are completed the hospital is the property of the local taxpayers. Under the system where the hospital district enters into an agreement with a Roman Catholic or other hospital to provide service, no attempt is made to buy the hospital building, the tax is lower and of course the taxpayers never own the hospital building.



The three hospitals which are working on this basis operate in a very satisfactory manner with the hospitals receiving guaranteed payments and an established area while the ratepayers are receiving a very satisfactory service.

Electron Microscope Destroyed

The story of how a very powerful electron microscope in the University of Vienna was destroyed prior to the capture of Vienna by the Russians is told in the last issue of *The National Geographic.*

This powerful two-ton machine had "lenses" made up of clusters of wire electrified by a 100,000-volt current. After this machine had been built and the Nazis had taken over, the Nazi government sent Professor Jorn Lange to take charge of the physics laboratory at the university.

As the Russians approached Vienna, the Professor stated that his orders were to smash the microscope rather than to let it fall into the hands of the Russians. To his fellow-professors this sounded so much like sacrilege that they agreed to prevent him from doing so and were prepared to go to any lengths to forestall the attempt.

When the downfall of the city became a foregone conclusion, Professor Lange was observed by two of his colleagues to go into a cupboard for his sledgehammer, which he had ready to destroy the equipment. One of his associates stayed with him to try to reason him out of this action, while the other went to call a member of the Underground Resistance Movement. The latter came back just in time to see Lange strike at a delicate part of the instrument. The two professors, with the Underground operator, rushed him. The Resistance member was knocked out at once with a blow from the hammer. Then, using a table as a shield, Lange was able to get over to a drawer and obtain a revolver. He immediately shot one of the professors dead. The other hurled himself at Lange's legs and, in turn, was shot dead. Lange then proceeded to smash the machine to bits.

Later he was arrested as a major war criminal.

Urology Award Announced

The American Urological Association offers an annual award, not to exceed $500, for an essay (or essays) on the result of some specific clinical or laboratory research in urology. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, for full particulars.

Adequate Medical Records
in the Small Hospital

By ISOBEL H. MARSHALL, R.R.L.,
Brantford General Hospital

PERHAPS it has been your pleasant experience, as it has been mine on various occasions, to visit the medical record departments of the larger institutions. Upon entering you are amazed; how well staffed the department is; the tremendous volume of work which seems to be in progress; the spaciousness of the department, and many other things. Your thoughts quickly turn back to your own department in the smaller hospital, and the comparison between the two is very marked. But the size of the hospital or department should have no bearing whatsoever on the quality or importance of the material being compiled. Each patient in the hospital should receive the same clinical or scientific consideration and at no time should the importance of the patient's chart be overlooked.

Let us consider the personnel involved in securing the medical record. It is true that the attending physician carries the responsibility but there are heads of departments clearly responsible for contribution to the medical record in the reporting of information obtained, or results of tests and examinations carried out in their department. Briefly these are: admitting department, laboratory, radiological department, dietary department, out-patient's department, physiotherapy department, nursing staff and lastly, the medical record department, whose duty it is to organize all information submitted by the various departments, so that a complete file of the patient's medical record may be available at all times for reference and study.

Let us commence with the admission of the patient. The admitting department is responsible for securing such information as correct name and address, age, marital status, religion, nationality, etc., and also controls the routing of patients to the various wards of the hospital and at the same time exerts a distinct psychological influence on patients, relatives, friends and personnel. It is my understanding that in some of the smaller hospitals the admitting of patients is handled entirely through the business office. This has its disadvantages as well as its advantages. Perhaps it is difficult to determine just where the former lie. Could it be that no one person is made responsible for this duty? To admit a patient accurately and to take into consideration the psychological standpoint, the clerk should be familiar with all the information recorded when the doctor arranged the admission of his patient to the hospital, that is, she should know the admitting diagnosis, the type of ward she or he desires and if it is suitable. All this data should be obtained as pleasantly and with as little embarrassment to the patient and relatives as possible; it is frequently the first impression which remains with them throughout their hospital stay. This problem might be taken care of by the appointment of one clerk only, over a reasonable period of hours daily, to be responsible for the booking, admitting and placing of patients.

Accurate information on the admitting slip is essential, as it is from this the patient's chart is commenced, and it plays an important part throughout the whole stay. Various methods of commencing the ward chart are used in different hospitals; in our own, a copy of the admission slip is forwarded to the medical record department at stated hours during the day. The department is responsible for the typing of the chart cover, and delivery of it to the ward.

Responsibility of the Nursing Staff

The chart as a whole is made up on the ward and becomes the responsibility of the nursing staff. As to the type of forms used in different hospitals, they should be most suitable to the type of hospital, the main factor being the information which is recorded thereon. Apart from the functional inquiry, personal history, physical examination and progress of the case, the information contained on the chart depends on the promptness, accuracy and co-operation among the supervisors of the wards and heads of the various departments. This, I maintain, is out of the librarian's list of duties. Nevertheless, the students should be taught thoroughly the importance of charting. They should be concise in their remarks but accurate. Their writing should be legible and they should avoid ink blots. In hospitals where the instructress of nurses does not have time to impress upon the student the value of charting, it works out particularly well when the librarian has been given the privilege of giving the student nurses a few short talks on this subject prior to the period of training when they commence charting.

History Taking Without Interns

In the larger hospitals, or even in the more fortunate smaller hospitals, the intern plays a very convenient and important part as far as the functional inquiry, personal history, physical examination and progress notes are concerned. Perhaps it might be of interest to know how to take care of this portion of the record without interns. At the present time at the Brantford General Hospital there is a graduate nurse, full time, taking histories of all patients in the hospital with the exception of the obstetrical department. You may wonder, without interns, how to obtain a provisional or working diagnosis on all patients, which as you know should be recorded as

(Continued on page 78)

Address, The Institute of Medical Record Librarians, held under the auspices of the Canadian Association of Medical Record Librarians at St. Michael's Hospital, October, 1945. Miss Marshall was formerly president of the Association.

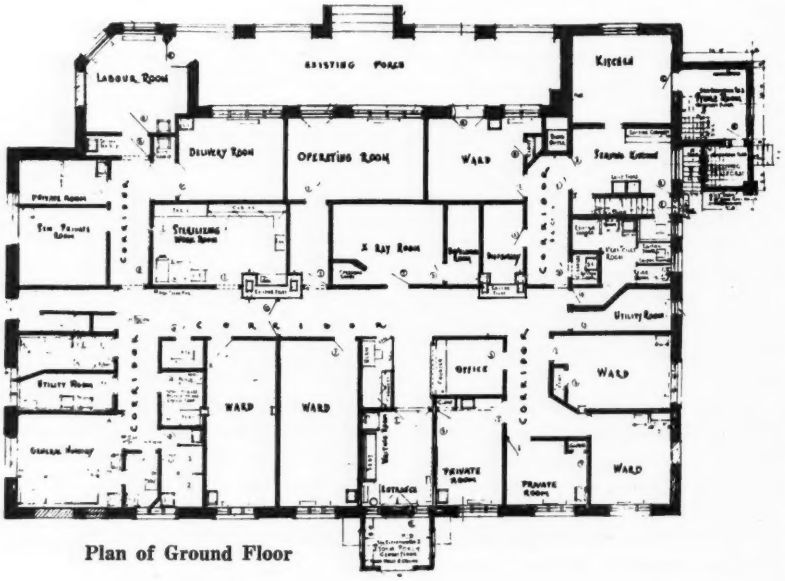


West Lincoln Memorial Hospital

Miss MacRobbie, Superintendent

MODERN SMALL HOSPITAL
Serves Rural Community

THIS newly equipped Hospital is located just off No. 8 Highway and Grimsby Beach Road, midway between Grimsby and Beamsville. The property was formerly the Deer Park Golf and Country Club, and was donated by the late Mr. C. J. Eames of Hamilton to the public for use as a Hospital in 1943, which first made the project possible.



Plan of Ground Floor

The buildings are located on an elevation about half-way up the mountain, overlooking beautiful garden-like fruit farms, with all the advantages of the city yet in the country. Its central location makes it ideal in every way to serve that area from Winona to Jordan and south to Smithville with an approximate population of 12,000 people.

The general plan developed under the supervision of the Department of Health, Toronto, provides for an initial capacity of 20 beds, including three private rooms, four semi-private rooms, and two wards. There is an eight-cubicle nursery including isolation ward. Provision has been made to add five more semi-private rooms at an early date, which will

bring the capacity up to 30 beds plus nursery. A full complement of equipment is provided to care for emergency cases, fractures, minor surgery, obstetrics, pediatrics, and general medical cases. A most complete X-Ray Department is tied in with a consultant in Hamilton to provide an up-to-the-minute service.

An outstanding feature of this hospital is the decorating, drapery and furnishings, all of which have been carried out in soft colours, giving the institution a warm and homelike appearance. In this as in the providing of linens, etc., the Ladies' Auxiliary have completed a most creditable piece of work.

The founding and financing of this enterprise was first made possible by the donation of the building, and by the support of a group of public-spirited citizens, the Ontario Department of Health, the Council of the County of Lincoln and North Grimsby Township, in which the hospital is located.

A survey by the Academy of Medicine of Hamilton in 1944 showed that hospitalization was grossly inadequate and the people of this area took action to prepare for their own needs. In a recent house to house canvass to provide the final necessary funds, of 1000 letters sent out in one district there were 940 responses by way of donations, showing that 94 per cent of the people were behind the project.



Nurses Sitting Room

The hope has been expressed that this hospital will become an actual operating model of a small establishment. Many maternity cases, minor surgery, and convalescent cases welcome the opportunity of receiving hospital treatment in a small home-like institution.

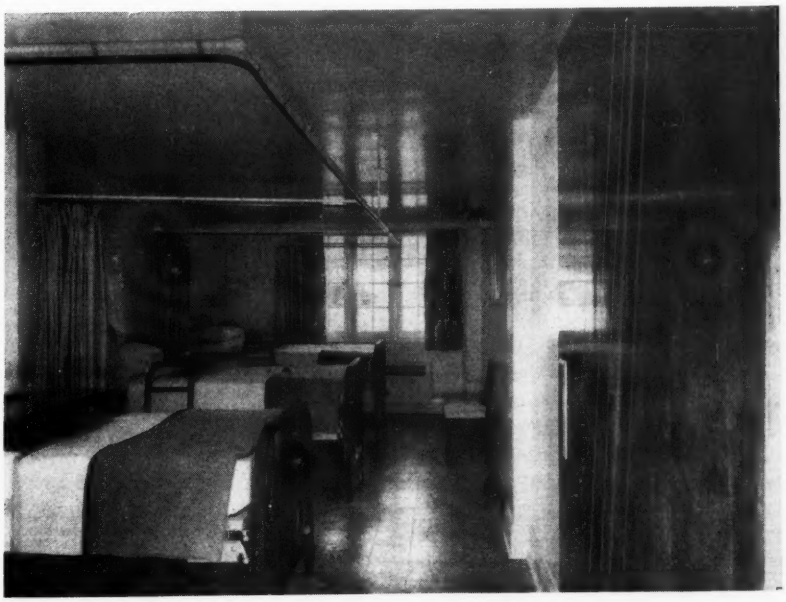
This need, together with that of a fitting living memorial for those who have gone before, including our war heroes, was the conception of the West Lincoln Memorial Hospital—a small complete institution to serve home needs.

In the accompanying photographs supplied through the courtesy of The Metal Craft Company Limited, Grimsby, the exterior of the Hospital is pictured as it is approached from the West. Other views show a portion of semi-private wards and individual permanent cubicle curtain arrangements, and a corner of the staff reading room.

The development of the West Lincoln Memorial Hospital is typical of the requirements needed in many other small communities. It is compact, completely efficient, modernly equipped and will meet the needs of the community it serves for many years to come.

Development of the enterprise during the past three years has been carried through by a Board of Directors of: A. R. Globe, President, Grimsby; R. A Saunders, Vice-President, Beamsville; W. R. Boehm, Treasurer, Grimsby; J. H. MacMillan, M.D., Grimsby; O. W. Eickmeier, Grimsby Beach; F. B. Sutherland, Beamsville; B. H. Reid, Beamsville.

The five directors are elected annually by members of the Hospital; one is appointed by the County of Lincoln and one is appointed by the Medical Council. The hospital is in charge of Miss Douglas MacRobbie, R.N., who has now taken over.



Ward Room Showing Curtains

Obiter Dicta

Research on Number One Killer

THERE will be general approval of the recent decision of the Life Insurance Medical Research Fund to provide large sums of money for research into the causes of cardiovascular disease. For some years now cardiovascular disease has headed the list of causes of death and has rightly earned the opprobrium of "Number One Killer". Large sums of money are being spent, and rightly so, on reaserch on the cause of cancer, of infantile paralysis and of other diseases, but in the final analysis it is the tremendous increase in coronary thrombosis, arteriosclerosis and other cardiovascular diseases which is striking down so many of our most valuable citizens in their prime and helping to neutralize the many advances which have been made by medical science in controlling or eradicating other conditions. Although much has been said about this clear-cut increase in cardiovascular conditions, relatively little has been done to control it. The Life Insurance Medical Research Fund was organized last fall by some 147 life insurance companies on this continent, including a number of our larger Canadian companies. This grant, the first to be made by the Fund since its organization, is being paid to the medical schools of six universities in the United States to assist research projects in the field of heart and arterial diseases and to support younger Research Fellows who, without that support, would be lost to the medical research field. Grants totalling $126,000 have already been made and it is anticipated that the Fund will have available over $500,000 during the present year. A total of $3,500,000, to be used in research in this field, is in prospect over a six-year period. The grants made by the Fund have been recommended by the Medical Advisory Committee, headed by Dr. Francis G. Blake, Dean of Yale University Medical School, and approved by the board of directors.

This is a tremendous study which is being undertaken and the results will be awaited with considerable interest. Obviously this research is not of the type which would come to its logical end when it had isolated some organism and determined the method of control. The solution to this problem of increasing cardiovascular diseases may well lead the research workers out of the laboratory into the broader field of our whole social structure. We suspect that major factors affecting the solution of this problem may include our methods of working and living in general, our continuous high tension, our speed mania, our dietary, drinking and smoking habits and our anxiety over interruption of income. The study may lead into socio-economic conditions and should have a psychological as well as a physical aspect. It may well lead to strong recommendations respecting early inculcation in the next generation of changed values in life, with less emphasis on the amassing of money, or on things that only money can buy, less emphasis upon personal ambition and upon over-stimulating recreation and more stress upon the basic virtues of religion—in short, this study may well indicate the desirability of a new philosophy of life on this continent.

The Forgotten Man

MUCH is being said, and much is being done, about guarding the health of nurses and other employees in hospitals. Pre-employment physical examinations and careful check-ups during employment, especially of student nurses, are being more widely adopted. Free medical care, donated by an obliging medical staff (usually the same few members) is provided to all who are sick in the residences or on the wards. But little is being done in most hospitals about the health of the interns.

Very few hospitals indeed have a physical examination made of the interns when they report for duty. They come to the hospital worn out from one of the hardest university courses in existence, in some instances right after writing their "Council" examinations as well. University student health services seldom, if ever, include a final graduation examination. They start right in on a gruelling schedule, accentuated in most hospitals by an inadequate number of interns, a shortage of attending staff, a surplus of patients and an ever-increasing gamut

of procedures to be carried out. On or off duty, there is a constant atmosphere of tension and excitement in a hospital, sleeping quarters are seldom really quiet and rest is constantly broken. The writer well recalls one stretch in his own white-suit days when he was not able to lie down for 51 hours. It is easily understood why, in one of our large hospitals some years ago, four interns went down with tuberculosis in one year. Interns could easily be open cases when they report to the hospital and nobody would detect the situation.

There should be some member of the visiting staff—perhaps in large hospitals a medical assistant superintendent—whose duty it would be to guard the health of the interns. He should arrange an initial physical examination, arrange reliefs for those who are getting sick, order the conscientious ones to bed when indicated, check on living conditions, and set up reasonable schedules of duty and rules for the intern quarters to ensure rest. We know of two interns who died of illnesses that were badly aggravated by the fact that they continued on duty long after they should have gone to bed. Being doctors, interns are left to chart their own courses when threatened with illness, but, being young and enthusiastic, they hate to quit and let their chief down or load some scut work onto an already tired comrade. The medical staff of every hospital employing interns should look seriously into this matter and take whatever action is necessary.

Our Fight for Health

THIS fight for health has gone on since man realized that he had some control over himself and his environment. More progress has been made in the last fifty years than in all previous history. We have every reason to expect that these advances will continue. We must realize today that any community which has a case of typhoid, diphtheria, scarlet fever or smallpox, is falling down on the job. The pasteurization of milk, as required in Ontario, is an elementary but essential precaution which should be compulsory everywhere. Those great scourges, tuberuclosis and venereal disease, can be wiped out by the known methods of diagnosis and treatment, and the removal of the social conditions which bring them about. Each year in Canada proper care would save the lives of 800 mothers and 6,000 children. About 30 per cent of all blindness can be prevented or cured.

We Canadians are at our best when we have a hard job to do. The bigger the job, the better we do it, provided that the purpose is clearly defined. When we were challenged by the Axis powers in the war, we never faltered. We "measured ourselves against history". Now that peace has come, the challenge is equally clear. Our enemy today, instead of being Germany or Japan, is disease and unhealthy conditions. In meeting this challenge, we must never forget what we have done in the past. We must not forget the splendid contribution our medical men, our nurses, our scientists have made in the field of curative and preventive medicine. The objective lies before us crystal-clear. The horizons are there, and with each fresh advance we push them back to reveal new goals for which to work. We have the medical skills; we have, in increasing measure, the physical plant; we know what should be done and we can easily work out the details of how it should be done. The Canadian people want, and I believe are prepared to pay for, just as good health as anyone can have.

(From an address by the Hon. Brooke Claxton, K.C., Minister of National Health and Welfare, at the annual meeting of the Health League of Canada).

Ten a Year, Limited

A UNIQUE method of finding suitable employment for worthy young men and women was worked out before the war by a group of seven prominent business men in Toronto. They formed a company known as "Ten a Year, Limited". This company has an Ontario charter and has a total capital stock of 100 shares, issued at the rate of ten a year. It is a non-profit company with its capital of $1,000 provided privately. Although temporarily discontinued during the war, it is now proposed to re-open the plan.

Each year in March ten members of the graduating class in Chemical Engineering (U. of T.) will be selected as shareholders. They will be selected on the basis of (1) character record and (2) scholastic record. In the first year the seven directors are responsible for placing the ten "shareholders" in commercial or professional positions. When placed, the ten shareholders will in turn act as outposts to assist the directors in locating openings.

Certain restrictions are set up. Character is considered above all other qualifications. Not more than two of the ten shareholders selected each year may be fraternity or sorority members. No shareholder shall indulge in alcoholic liquor in any degree under any circumstances; violation means that membership is forfeited automatically. This has been decided upon because the directors have seen too much of the deleterious effects of alcohol upon a budding career. For the first three years no shareholders may become a director. Monthly meetings are being arranged. Each new shareholder receives an "Engineer's" wrist watch, financed from special funds. The men behind this plan have all been well-known business leaders—Harrison Smith, the former president of Imperial Oil Co., Ltd.; Denton Massey, M.P.; Dr. H. B. Speakman, director of the Ontario Research Foundation; Charles R. Vint, president of Colgate-Palmolive-Peet Co. Ltd.; A. G. Partridge, president of Goodyear Tire and Rubber Co.; H. A. Wilkins, president of Lever Bros. Ltd.; and Allan Ross, president of William Wrigley Jr. Co. Ltd. The Hon. W. L. M. King is Honorary Chairman. Professor Bain aids in the selections.

This plan has much merit. Deserving young people are given the opportunity they need. They have behind them a group of seasoned business leaders upon whom they can call for advice. They in turn assume a responsibility to help others who follow them. Newly-fledged theorists meet experienced realists to mutual benefit. It would be well worth the effort if some such plan could be evolved for different groups in the hospital field—hospital administration, nursing administration, technical services or among the dietitians.



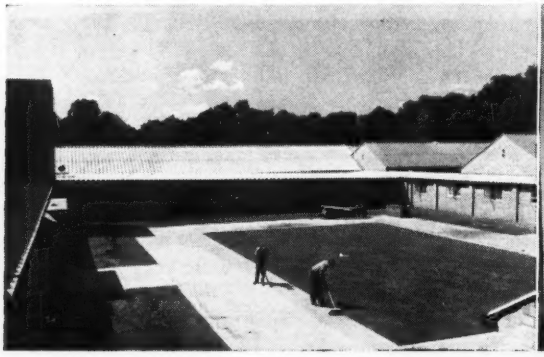
Canada's War Memorial in Britain

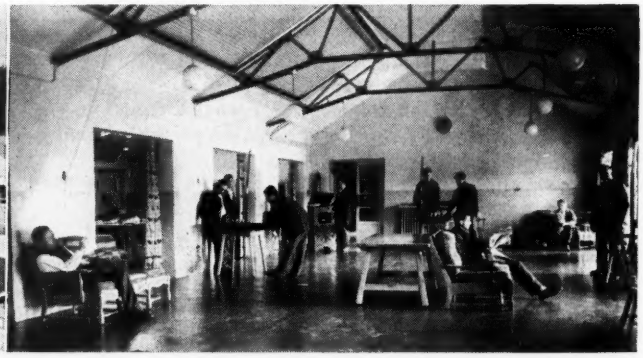
THE 600-bed Canadian Military Hospital on the grounds of Cliveden, the Astor estate near Maidenhead, is to become an institution for research into heart disease in children, as Canada's war memorial in Britain.

The £500,000 ($2,500,000) hospital, opened early in the war to care for sick and wounded Canadian troops, soon will be presented to the National Trust. Erected by the Canadian Red Cross, it was turned over to the R.C.A.M.C. for use first by No. 5 C.G.H. (Winnipeg), then by No. 7 C.G.H. (Halifax) and finally by No. 11, a composite unit.

The last Canadian patient has left and the final work of putting the hospital in order before it is handed over is expected to be accomplished early this month. Canadian authorities made the request that it become a specialist hospital carrying out research into children's heart ailments.

The hospital occupies 22 acres of the Cliveden estate, rented for the duration to Canada for one shilling a year. During the last war, Canada had a hospital there also.





The Greatest Modern Englishman

Part II

A Surgical Renaissance

(Concluded from our January issue)

By W. HARGREAVES,
Vancouver, B.C.

LISTER now devoted his thought to the elaboration of his system, which entailed a mass of details. These details, while essential to the system, are not really essential to this story, though they have entrancing academic historical interest.

Of the four named hospital diseases—erysipelas, pyemia, septicemia and gangrene—the latter was the most pernicious. Assuming this to be the case, antiseptic measures to be used had to be potent enough to completely extirpate the deadliest germ.

The new system embodied three essentials:

1. To destroy the germs on the patient's skin at and surrounding the wound, at the same time rendering aseptic all the instruments and everything else in contact with the operation, including the hands of surgeon and assistants;

2. To prevent germs from entering the wound during operation;

3. To prevent germs from spreading into the wound after operation.

Note that he did not stop to find an academic name for the germs. There would be ample time for classification when he had proven what would destroy them. Later one of his students, Dr. Watson Cheyne, made the bacteriology of Lister's cases his specialty.

The three recorded precepts constitute the original Listerian principles. They are as inviolable to-day as they were when first enunciated. They meant and continue to mean possibilities in surgery that previously had been dreams of fantasy.

Edinburgh Again, A.D. 1868

After eight years in Glasgow Lister was invited to return to Edinburgh as Professor of Surgery. His system had been practised for three years, and the cumulative evidence by those who had taken the course of study showed that it had tremendous advantages and offered an ever-widening vista for scientific exploration. His students had come to hold him in the highest esteem, amounting to veneration. One Highland student talking to his fellows spoke of Lister as "Chief". The significance of this term may not appear to the Sassenach, but to a clansman it expressed the loyalty and devotion that these clans give to their chief.

Now that it could be performed with safety, aseptic surgery was extending its scope. This brought to Lister's attention the frequency of suture abscesses. Again, his reasoning led him to believe that the catgut was not being prepared in accordance with his proven principles. He thereupon decided to prepare his own catgut and so test this assumption. This decision came at a time when he was holidaying at his parents' home. With the innate zeal to solve a problem, he was able to persuade his father to permit him to make the necessary tests right there. It meant careful preparation of the gut, following which he sutured it into a calf. The environment did not provide the facilities of his own laboratory, but he proved his premises to be correct. Subsequently the animal suffered no inflammation, no suppuration, no irritation, and later it was found that the catgut had been completely absorbed. Based on this simple, homely incident, the catgut in common use the world over is prepared to-day according to Lister's first principles.

After another seven years, at the age of 48, he was invited to the chair of Clinical Surgery at King's College, London.

It was not easy to leave the scene where he had sucessfully worked out his great ideal. The Scottish home and the numerous friends were dear to him and his wife. They were surrounded by a wide circle of professional associates, doctors and students who had proclaimed him Chief in devoted admiration of his outstanding pre-eminence. No doubt, his personality had enabled him to impress his new system upon those near to him. Not for pecuniary gain, nor for personal aggrandisement had he laboured, but rather for the amelioration of unspeakable suffering and sorrow on the one hand and the exaltation of his profession as a means to that end. The high ideals which characterized his motives were also characteristic of his deportment. To the poor he was as gentle as to the wealthy. He treated the public ward patients with the same care displayed when he operated on Queen Victoria. He required discipline, yet his harshest rebuke—acording to record—to a student who was careless in handling a patient was "A feeling heart is the first requisite of a surgeon".

Ever considerate for the other man, his modesty probably detracted from his own achievements and renown. He vaunted not himself, was not puffed up. At the Pasteur Jubilee in 1892 Lister was asked to speak. With a kindly smile he turned towards Pasteur and said simply: "Thanks to you, surgery has been stripped of its ancient terrors and has thus enlarged its power without limits." What wondrous magnanimity! He who had wrought such a beneficient revolution in the universe

of human suffering, with a simple gesture of honest modesty lays his life's work at the feet of the other who had contributed one idea.

William Henley, a contemporary poet who was a patient of Lister, wrote a sonnet which closes:

"His wise rare smile is sweet with certainties,
And seems, in all his patients, to compel
Such love and faith as torment cannot quell.
We hold him for another Herakles
Battling with custom, prejudice, disease
As once the son of Zeus embattled death and hell."

London Again, A.D. 1875

The time had come when, despite all the ties that bound him to the north country, Lister felt impelled to change the venue of his labours. London was the centre of the circle wherein what Lister knew to be veritable truth had not been comprehended. There yet remained many in his homeland who failed to understand the new system. The cool reception in some places will never redound to the credit of the older British surgeons. Some were hidebound to their old practices, others tried to use the new system but failed because they had not studied its detail. They failed by not knowing and, unfortunately having failed, they condemned it. Doubtless this lack of apprehension of his system and its inaccurate application influenced Lister to accept the call to the Professor's chair at King's College.

The early days in London were difficult, yet he was prepared for that possibility. When he was in London for his first term he had written to his father: "I trust I may be enabled in the treatment of patients always to act with a single eye to their good and therefore to the glory of our Heavenly Father." The twenty years' absence—what a revolutionary 20 years—had not worn out that simple unassuming faith. And that is the spirit in which he began his professorship.

The prejudiced and the sceptics could not withstand the unobtrusive honesty of purpose, while the unknowing ones were convinced by the marvels of his practice. His personality linked with his demonstrations gradually broke down all opposition from the older practitioners, while the younger men became the same enthusiastic disciples as those he had left in Scotland.

Foreign Acclaim

While progress of the new practice in Britain was evolutionary, on the Continent it was revolutionary, and displaced the old system as quickly as it was understood. Whether or not this was because the great prevalence of hospital diseases had reached a desperate climax, certain it is that the new gospel was accepted with enthusiastic acclaim. Eminent surgeons from abroad visited London to get the exact technique by witnessing Lister's demonstrations.

One incident will typify the many instances. In Munich the hospital disease problem had become formidable; 85 per cent of the patients were dying. The authorities had tried every known method to overcome the trouble without avail. They were actually discussing the advisability of destroying the hospital, of burning it down to eradicate the infection. Then they heard of Lister's system. The chief surgeon put on record what subsequently happened. The system was applied exactly as observed in Lister's demonstration. The record runs: "When in the course of a single week we applied to all our patients the newest antiseptic methods and did all our operations according to Lister's system, everything went well. We experienced one surprise after another, not a single case of gangrene occurred. Our other cases became better and better, and eventually hospital diseases, which were carrying off 85 per cent of our cases, totally disappeared."

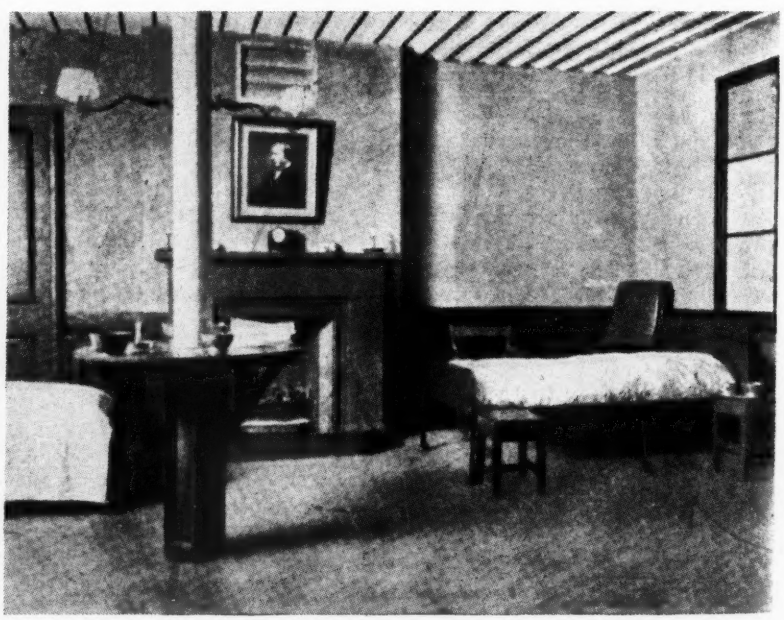
Aseptic Surgery Universal

In the quotation above and in general terminology the system was named "Antiseptic Surgery", for the reason that Lister used antiseptics to produce aseptic conditions. The ultimate objective was *asepsis;* antiseptics were the first media used to that end. While antiseptics serve the same purpose to-day, in the course of time newer measures were adopted. The properties of aseptics have become focalized in the sterilizer. The sterilizer is the engine of asepsis. It is in the sterilizing room that the arbitrament of infection is decided, that the general pestilence is to be eradicated.

Hospital Diseases! Never again! Never so long as the Listerian principles and the Lister Spirit dominate surgical practice.

The transformation transcends the most vivid imagination. Numerous and great have been the inventions of the past seventy years, yet nothing approaches Lister's innovation in its influence upon the welfare, health and happiness of mankind in this age and all the ages yet to be.

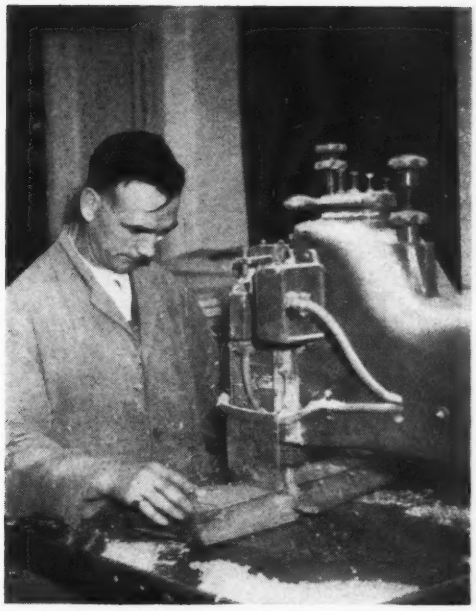
(Continued on page 74)



The famous "Lister Ward" at Glasgow, where Lister perfected aseptic technique.

St. Dunstan's

Plays Its Part



A blind Service man at work on a router. This is a machine on which a blind man can soon become expert.

WHEN war came in Europe, it was realized that the white building of St. Dunstan's, standing high up on the Downs which rim the south coast of England, would be a vulnerable target from the air. And so this big organization, which trains blind men and women—teaches them how to be independent, how to earn their living and be of use in the world—went to a safer place in the depths of the country. And in the country its work goes on—the work which helped over 3,000 men, who had been blinded in action during the war of 1914-1918, to regain their self-confidence.

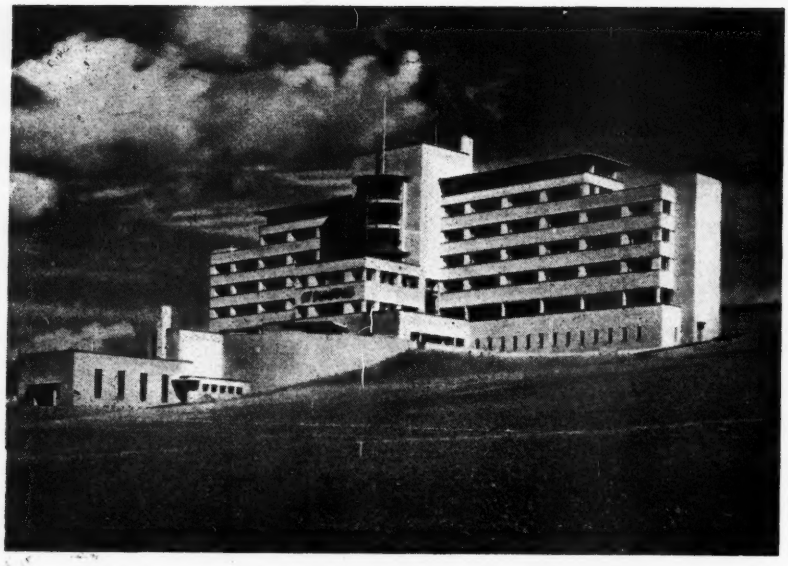
In this war, too, splendid work has been done—for men blinded in the Forces, and for men and women blinded in air raids or in war factory accidents. In this war, in fact, greater advances have been made than ever before. Blind people—not only those blinded recently, but also some who have been blind from birth—have been trained to do vitally useful jobs in factories. They do routing, assembling, sand-blasting, soldering—all kinds of jobs where a keen sense of touch and concentration is valuable. In some cases one operation has been broken down into several to make it easier for them to carry out. These and other adaptations to machinery, such as the fixing of bells instead of light signals, are very simple, and it may be well



A young Army engineer who has lost both hands as well as being blinded. Despite his handicap he has, with the aid of steel pegs, become an efficient typist.



A blind telephone operator, who is employed by the British Ministry of Labour. Blind men can do most jobs in which a keen sense of touch and great powers of concertration are valuable.



worth an employer's while to have them effected. A blind man can work as fast as a sighted one, and because he is not distracted by the sight of things round him, he concentrates in such a way that he can tell at once if there is the slightest thing wrong with his machine. Instructors at St. Dunstan's find that they have first to give their pupils a "look" at the machines by placing their hands on the various parts and simultaneously explaining the functions of these parts. Soon the men find that certain movements produce certain results. And it is not long before they are really making parts for aircraft or other machines. Knowing that they are doing a useful job is a tremendous help towards recovery from the shock of losing their sight.

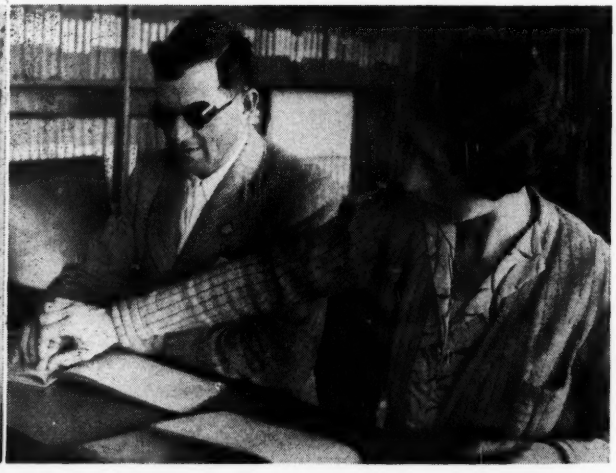
Right:
Before the war an annual regatta for the blind was organized by St. Dunstan's. Here are some blind oarsmen arriving for a regatta on the River Thames.



Below, left:
A St. Dunstan's-trained masseuse, who was blinded in the 1914-1918 war, teaching two men who lost their sight in the second European War.

Below, right:
This man is learning to read braille. The first thing a blind person is taught at St. Dunstan's is to tell the time on a specially designed watch.





When a blind person is first admitted to St. Dunstan's, he is given a special watch. This has no glass, but its hand are very strong and its face is marked with dots. In about two days, he has learned to tell the time by touch. Then he begins to learn to read and write, and in a little while he is ready to go to the training school. In their leisure time, trainees hold dances, go for walks, etc. They have a large library of "talking books" — specially made gramophone records with threads cut more closely together so that they play for 25 minutes. A short novel takes about ten records.

Through this training, St. Dunstan's enables many blind British men and women to find a useful niche in the world. Sir Ian Fraser, the chairman, was himself blinded in the last war when he was only 18 years old. Yet he has become a member of parliament. With that example before them, Britain's blind people realize that their handicap is one which can be very largely overcome.



Blind ex-Servicemen are assisting in the construction of aircraft. Their job requires great skill and precision and their powers of concentration enables them to equal and even exceed the output of a normal worker. Picture shows a man who was blinded in the last war and is an inspector of aircraft components made by his colleagues at their factory. He is being led past the wing of a Miles Master training plane by his dog Tessa, who also guides him to work.

Donald M. Robertson, M.D.

Hospital administration in Canada lost its Dean in the death on January 6th of Dr. Donald M. Robertson, formerly superintendent of the Ottawa Civic Hospital. Dr. Robertson died after several months' illness in the hospital for which he had laboured so long and enthusiastically. Born in Perth, Ontario, he taught school for some years before going into medicine at McGill University. Graduating in 1898, he interned at the Royal Victoria and took postgraduate work in Edinburgh and Glasgow. In 1903 he was appointed superintendent of the old Carleton Protestant General Hospital in Ottawa, a post which he held until 1924 when the new Ottawa Civic Hospital was opened under his direction. This latter post he then held until his retirement in 1939. Since then he served as medical consultant to the hospital and for over two years represented the Canadian Hospital Council as advisor on hospital equipment to the Department of Munitions and Supply.

Dr. Robertson was long an honoured figure in Ottawa and in hospital circles. As a student he was purser on the old Ottawa boat "Empress" and his inability to note many Ottawa youngsters slipping over the rail won him lifelong friendship with many of Ottawa's future leading citizens. A keen horseman, he was active in hunt club circles and in the promotion of horse shows and winter fairs. A charter member of the Ontario Hospital Association, he was its president in 1935. He was also a trustee of the Royal Ottawa Sanatorium and held various positions of trust in Ottawa. The Canadian Hospital Council had no warmer supporter in its early days. Dr. Robertson, who never married, is survived by three sisters and three brothers.



Dr. D. M. Robertson.

Major Gage to Vancouver

Major Gladys Gage, formerly of Calgary, has been appointed superintendent of Vancouver Grace Hospital. Major Gage, a graduate of Windsor Grace Hospital, has previously been superintendent of nurses at St. John's, Newfoundland and hospitals in Ottawa, Montreal and Toronto.

What Can an Auxiliary Do?

By MRS. J. M. GEORGE,
Morden, Manitoba

ALTHOUGH the war is over, we still think in terms of war. May I compare a complete hospital organization to that of an air force organization: the hospital and equipment as the Base, the doctors and nurses constituting the air crew in the main line of attack against the enemy, disease. But for every one in air crew there were at least nine in ground crew, so perhaps we might include the hospital Boards or Trustees, assisted by the Ladies' Aid, in the "ground crew". We know the necessity of perfect co-operation between ground crew and air crew in the Air Force—this same co-operation between the various groups engaged in hospital work is just as essential. May I emphasize the importance of the work of the hospital aid in promoting good hospital service.

There may be a tendency on the part of some trustees to discourage the efforts, or the organization, of hospital aids, through fear that the ladies might wish to usurp some of their powers, or tend to dictate policy. This is—or should be—farthest from our minds. The motto of hospital aid is: "We do not want to run hospitals, we want to make it easier for hospital boards and superintendents to do so."

In the air force, each branch has a separate, distinct duty to perform, but the success of their efforts is dependent upon each group knowing fully the needs of each other group in the service. So, if the work of the aid is to be effective the members must know the problems and needs of the hospital. They can only know this if they are kept informed by the Board; if the Board realizes the benefits of an aid, they will not hesitate to do so. This can best be accomplished by frequent contacts between the members of both organizations, by having representatives of the aid at the regular Board meetings, "listening", or perhaps one general meeting each year at which all members of the Board, the staff and the aid are invited to attend and discuss hospital problems.

Perhaps I might mention briefly the work undertaken by our own auxiliary. They considered their first duty to be the furnishing of the hospital with an ample supply of linen and keeping the linen in good condition. Then equipment, such as dishes, cutlery, etc., was purchased. They have devoted their attention to providing comforts for the staff and have also assisted the Board when necessary in furnishing dietary supplies.

The money necessary to carry out the above programme, even in a small rural hospital, amounts to quite a substantial sum, and must be raised by the aid. Instead of making frequent appeals to the public throughout the year, our aid prefers to raise their money by one or two main annual events. This plan seems preferable when there are so many other organizations also deserving support.

In the course of an address to the Canadian Hospital Council last September, Mrs. Margaret Rhynas, who is recognized as the "mother of Hospital Aids" in the East, stressed the importance of hospital aids as public relations committees for hospital work. There is no doubt that a hospital aid can do a lot towards creating community interest in the work of the hospital, and can also help to counteract all unfair and unwarranted criticism levelled against hospitals and their staffs, generally through ignorance or the desire for gossip.

Do our citizens know all they should of our hospital—its needs and deeds? Sometimes criticisms are offered which stem from lack of intimate knowledge and personal contact with the institution. As aids, we can assist in giving citizens that knowledge, one way being to see that all church groups and other ladies' organizations are interested and kept in close touch with the hospital.

To function as an effective public relations committee the aid must be fully represented throughout the

(Concluded on page 76)

Address at November, 1945, Convention of the Manitoba Hospital Association.



Auxiliary of St. Joseph's Hospital, Sarnia

This auxiliary was organized in January 1945 and it now has a membership of 1,332. They have pledged themselves to the furnishing of the nursery of the new hospital at a cost of $10,000. Of this $6,000 has been realized this year. Despite the scarcity of raw fruit and the rationing of sugar they have contributed 1,000 jars of fruit, which is in itself a very substantial gift.

A stimulating approach to a timely subject

A Future for Preventive Medicine

(*A Book Review*)

THE third of a series of twelve books being prepared by the Committee on Medicine and the Changing Order of the New York Academy of Medicine has now been issued.* "A Future for Preventive Medicine" by Edward J. Stieglitz, M.D., is a worthy member of a series which, when completed, will cover public health, industrial medicine, rural medicine, medical education, research, nursing, dentistry, hospitals and government medical services—each by a competent authority in the field covered.

Preventive medicine may mean many things. Definitions may be highly restrictive or very general. Primarily the objective of preventive medicine by whatever means adopted is the *improvement of health.* We may be concerned with control of the environment to render it relatively innocuous or we may endeavour to improve the resistance of the individual to environmental influences.

If the focus of attention is shifted from the prevention of disease to *prevention of depreciation in health,* preventive medicine takes on new significance. "Constructive medicine" implies the improvement of health rather than the lesser factor of avoiding disease. There has always been a tremendous resistance to merely preventive or negative effort. On the other hand, the construction of health has positive and aggressive implications.

Health is not an inalienable right; it is a privilege. And privileges invariably entail equivalent responsibilities. As a people we do not yet realize that "the health of men and women is their own responsibility". Repeatedly the author emphasizes this point. "A social attitude of pampering paternalism, exaggerated by governmental policy in the last decade, has encouraged the belief that everyone is intrinsically entitled to health, security and ease without personal effort."

The causation of disease is always a combination of several factors. The sooner this is realized the more rapidly will preventive medicine advance.

The author's comments upon the sheltering and preservation of the unfit would seem to be quite sound, biologically speaking, but many will not agree with his conclusions on other grounds. He feels that man is flaunting the laws of Nature by so actively encouraging and abetting the survival of the relatively unfit. The removal of adverse elements from our environment may actually be weakening rather than strengthening the quality of humanity. He considers the prevention of chronic disease and disablement more urgent than attention to acutely fatal disorders. Many valuable statistical tables and data are given.

As for a future programme, the present public health approach must be continued and expanded. So-called "health programmes" that are merely state subsidies to the sick are not an adequate answer to the national need. There is no desire to do away with existing public or private agencies concerned with preventive medicine, but before more are added they should be checked as to their basic motivation, their competence and their place in the overall plan. Physical fitness is a fine objective, but service statistics show that the rate of rejection of star athletes exceeded the average of all examined. Research should be continued. Education in health should be under the direction of physicians who know the subject. The educational potentialities of industrial medicine have not been fully utilized.

We now have "well baby clinics", but "well adult clinics" are virtually unknown. "Health inventories" should be encouraged, and they should be more carefully done than is now the case with so many periodic examinations. Functional reserve capacities of individuals should be more thoroughly studied to detect early depreciation. Mental hygiene is particularly desirable. But again and again he stresses the personal responsibility of the individual to maintain and improve his own health.

It is a thought-provoking book.

H. A.

"The assumption that people have a 'right' to health is as false as the notion that everyone is entitled to freedom from want. Nothing could be more viciously destructive of initiative, effort and progress. Health is a privilege, not a right. And as a privilege it demands the acceptance of individual responsibility for conservation."

**A Future for Preventive Medicine by Edward J. Stieglitz, M.S., M.D., F.A.C.P. Pp. 73, illustrated. Price $1.00 (U.S.). The Commonwealth Fund, New York, 1945.*

With the Hospitals in Britain

By "LONDONER"



C. E. A. Bedwell

Dear Mr. Editor:

In the midst of the grave problems which confront the British Commonwealth and Empire, there seems to be some risk that one which underlies many of them may escape attention. If that great organization is to maintain its strength to contribute to the peace of the world, a primary essential would seem to be the growth of that portion of the population which has the greatest share of the responsibility. The steady fall in the birth rate, which has been taking place for years, is a serious factor in that connection. In this country a Royal Commission under the chairmanship of Lord Simon, formerly Lord Chancellor, is engaged in a thorough investigation of all aspects of the problem. Among the voluminous evidence which the Commission have received is a memorandum from Dr. Innes Pearse, well known as one of the directors of the Pioneer Health Centre.

Dr. Pearse bases her observations upon the experience of fifteen hundred families which have been members of the Centre. Her first point dissipates a common impression. "No bigger mistake could be made," she writes, "than to conclude that contraceptives are the predominating cause of the fall in the birth rate. Contraception is a method. The fall in the birth rate is the consequence of some deeper underlying factor." The memorandum then proceeds to examine the causes, which contribute to this national deficiency. A leading place among them is given to the "load of fear". In this connection it is submitted that (1) the attitude to pregnancy taken up by the Medical Profession as a result of a very proper anxiety to counter mortality and morbidity due to pregnancy in the sick moiety of the populace; and (2) the preventative propaganda resorted to by the health authorities, have both so deeply imbued the public with a sense of the dangers to be faced, that young couples have come to regard pregnancy as a *disease*—like other diseases to be avoided!

Factors in Declining Birth Rate

Justification for the contention set forth in Dr. Innes' memorandum can be found, if it were needed, in a report by the College of Obstetricians and Gynaecologists containing proposals for the development of a national maternity service. Dr. Pearse and her colleagues at the Peckham Health Centre have laid stress upon the infant being born in the home as the real foundation of family life. This is made possible by the fact that we have a trained midwifery service competent to take responsibility for the confinement. In fact something like ninety thousand cases were booked by that admirable body of nurses, enrolled under the auspices of the Queens' Institute, and no doctor was engaged to take part in them. The efficiency of their work is demonstrated by the fact that the maternal death rate of the women under their care was only a fraction of the figure for the whole country. That is only one section of the confinements which take place in the home.

A Medical Specialty

Nevertheless the whole bias of the report of the Royal College of Obstetricians is in favour of making this a specialty of medicine by the development of specialists. On the other hand it is only fair to add that the College have co-operated with the Central Midwives Board, which is the statutory body to deal with the training of midwives, in extending the authority of the midwives to make use of gas and air analgesia on their own responsibility. Public opinion will need a good deal of education before Dr. Innes' proposition obtains more general acceptance. The present tendency undoubtedly is to go into hospital for confinement. There are even signs that the expectant mothers are anxious to be in the care of a consultant rather than an obstetric Registrar, who may be in charge of the maternity unit. One large maternity hospital recently circulated a press paragraph that it is turning away expectant mothers at the rate of four thousand a year. It added that on the week end before the notice was issued seventeen mothers were delivered of their babies on trolleys and mattresses because all the beds in the hospital were full.

The issue must be clearly faced. If the birth rate is to increase by the popularization of maternity, then very definite practical measures must be taken to remove the prevalent fear. Even the general practitioners themselves dislike the maternity work. On other grounds the College express the belief that the qualifications for general practitioners to work in a national maternity service should be special and approved post-graduate experience. The solution may be found in an English compromise by attaching the midwifery work as far as possible to the health service as distinct from the hospital service and so making it part of the domiciliary services. Thus may we bring home to the young women of to-day that materity is the healthy function of a normal woman, through which she can make her contribution to the progress and peace of the British Commonwealth and Empire.

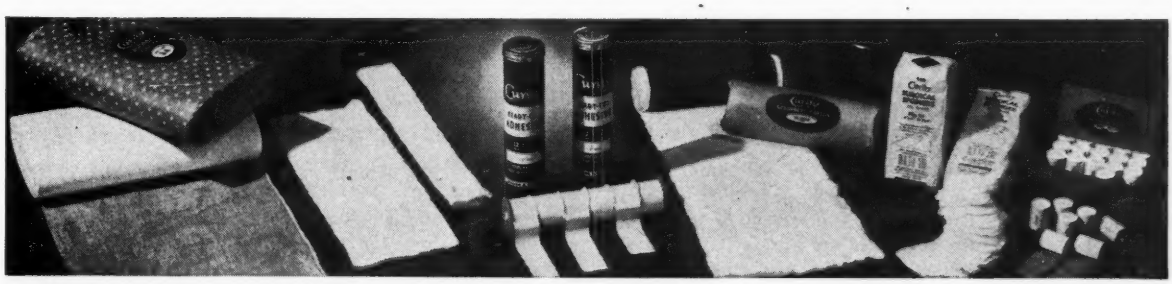


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Suppression of RADIO INTERFERENCE from Electro-Medical Apparatus

THE radiation from diathermy and short-wave apparatus, also other types of radio frequency generators, is now causing intense interference with radio reception. However, the interference from spark-gap equipment has practically disappeared since circular S 11-13-25 was issued in December 1941.

A new circular, S 11-13-28, dealing with the future control of all radiation on frequencies used for communications has now been issued. This stipulates that all unwarranted radiation must be suppressed by January first, 1948—not quite two years away.

It has been found that during the normal operation of this apparatus, radio-frequency energy at indiscriminate frequencies is radiated into space for great distances. There is resulting serious interference to practically all types of radio communication, including broadcast (AM and FM sound and television), government and commercial communication systems, aids to marine and air navigation, etc. Authority to suppress this interference is given by several Canadian Acts and International Conventions (Madrid and Cairo).

The new circular stipulates that when it is found that the operation of equipment causes serious interference to essential radio services, the interference must be suppressed immediately, or the use of the apparatus discontinued on the frequencies affected until satisfactory suppression of interference is made.

Responsibility for (a) finding a means of suppression and (b) actually suppressing the interference, lies with the users of the apparatus. However, the government will give advice respecting control without charge.

Most therapeutic radio-frequency generators now in use, because of inherent frequency instability, will not be permitted to operate after January 1, 1948, without being adequately shielded and the radiation suppressed, except for

(a) *Emergency cases,* when the patient cannot be moved to a shielded room or otherwise given treatment without causing radiation. (This would not include violet-ray and diathermy treatment in private homes, hospitals, beauty parlors or barber-shops; hospitals should provide a shielded room.)

(b) *Surgical cases,* Radiation from R. F. generators, such as a unit used exclusively for surgical work and operated for a few seconds only, may be permitted provided it does not interfere with essential communications and provided:

i Any single disturbance does not exceed 10 seconds;

ii Total disturbance does not exceed 30 seconds in any one hour.

iii Total disturbance does not exceed 100 seconds in any one day.

Where electro-therapeutic apparatus is operated without shielding (other than cases of emergency) only apparatus which operates within specified frequency bands shall be used.

As there may be unavoidable delay in obtaining apparatus of this type, users may continue to operate their apparatus for a reasonable time by obtaining authorization from the Department of Transport in writing. This would be issued only under certain stipulations.

In a communication Mr. G. C. W. Browne, Assistant Controller of Radio, points out the present difficulty in obtaining suitable suppressors. Apparently suppressors of suitable design are not now available and there is an excellent opportunity for the marketing of such equipment.

Representatives of the Radio Division, Department of Transport, are:

Mr. Walter A. Rush, Controller of Radio, Hunter Building, Ottawa.

Mr. W. J. Bowerman, District Superintendent of Radio, 413-418 Belmont Building, Victoria, B.C.

Mr. R. Ainslie, Supervising Radio Inspector, 404 Public Building, Calgary, Alta.

Mr. H. D. Tee, Supervising Radio Inspector, 400-401 Public Building, Regina, Sask.

Mr. G. Gray, Supervising Radio Inspector, 539 Public Building, Winnipeg, Man.

Mr. S. K. Ellis, Supervising Radio Inspector, 566 Dominion Public Building, Toronto, Ont.

Mr. J. M. Colton, Supervising Radio Inspector, 400 Youville Square, Montreal, Que.

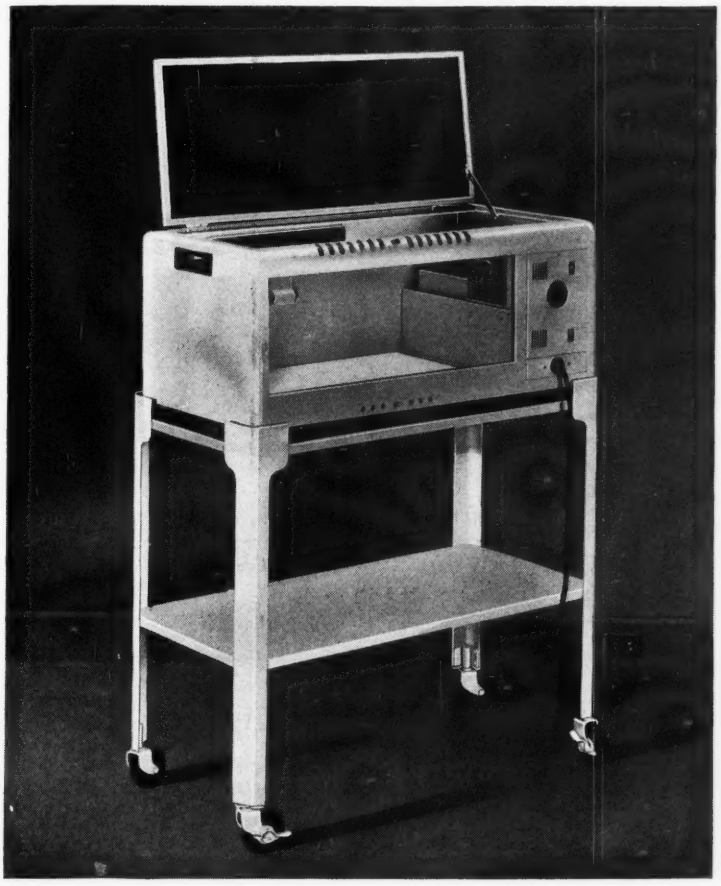
Mr. G. F. Harris, Acting District Superintendent of Radio, P.O. Box 217, Halifax, N.S.

Meeting Contingencies

Some economic contingencies are beyond the control of an individual to meet from his past savings or future earnings. In the short run, an individual's plight can be ameliorated by assistance (sometimes designated as "charity"); in the long run his hazard can be reduced by the use of the "insurance" principle, under which many individuals periodically pool a part of their income to provide money or services for themselves in time of need. These two procedures—assistance and insurance—are the basic features of any complete programme of security.

C. Rufus Rorem, Ph.D.

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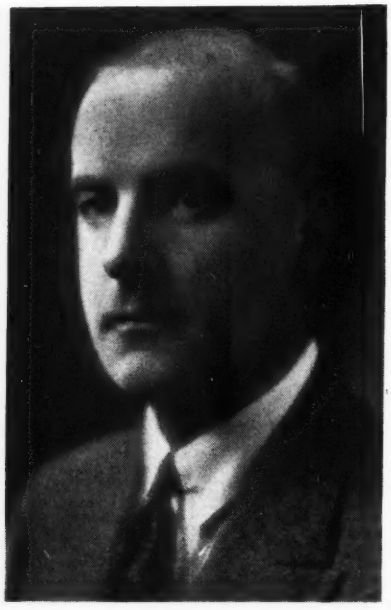
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25 Years' Service Honoured

In recognition of 25 years of faithful service to the McKellar General Hospital at Fort William, Ontario, Mr. H. H. Browne, the superintendent, was honoured at a presentation tea held recently in the nurses' home of the hospital. The president of the Board, Mr. W. R. Coslett, in making the presentation, referred to a motion in the minutes of a Board meeting held in 1920: "That Dr. McAvelia have an interview with Mr.



H. H. Browne, and if he is satisfied that Mr. Browne can fill the position of accountant, account collector, general utility man and assistant manager, engage him, no stated hours, seven days per week, 24 hours a day if necessary".

Mr. Coslett continued: "Before he had been with us a year he was made manager and secretary-treasurer, and in 1930 the Board of Trustees felt that the work of the institution could be improved by making a change in the then-existing set-up, and they appointed Mr. Browne as superintendent, with full charge of the hospital.

"During the past 25 years McKellar General Hospital has been through many strenuous times, each year becoming increasingly difficult, but Mr. Browne, with his natural executive ability and his accumulated knowledge and experience in hospital affairs, has kept the institution on an even keel. He has created a spirit of loyalty and enthusiasm among his staff which is hard to surpass and seldom equalled."

Mr. Browne is a member of the American College of Hospital Administration, and for the past fifteen years has been a director of the Ontario Hospital Association.

Dr. Piercey Chairman of District Association

Dr. W. Douglas Piercey, superintendent of Ottawa Civic Hospital, is district chairman of the Ontario Hospital Association. Other officers of the Eastern Ontario District are: vice-chairman, R. F. Armstrong, Kingston; executive, J. O. Barclay, Belleville; Major Hanna Janes, Grace Hospital, Ottawa; Sister St. Patrick, Kingston; Edith Young, Peterborough.

Health Department Appointment

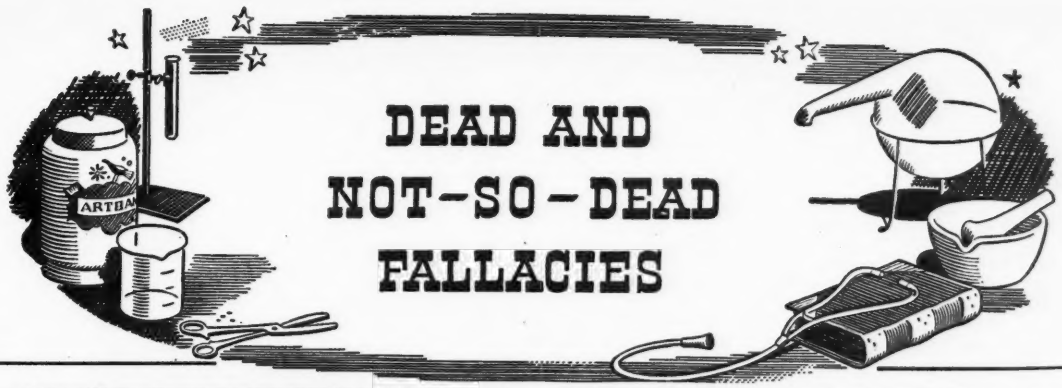
Miss Edna Hewson, Reg. N., for many years a supervisor on the staff of the Hospital for Sick Children, Toronto, has been appointed Nurse-Inspector of Hospital Obstetrical Services in the Ontario Department of Health. Prior to proceeding to her new duties, Miss Hewson spent some time in hospitals in New York, Jersey City, Philadelphia and Hartford, Conn.

A person's age is not dependent upon the number of years that have passed over his head, but upon the number of colds that have passed through it.—*Woods Hutchinson.*

How Hospitals are Buying Surplus Equipment in the United States

The U.S. Surplus Property Administration, in an interim order issued in December, announced that government and non-profit hospitals are now entitled to acquire property in the medical and health fields at a discount of 40 per cent of fair value in the purchase of surplus property. At a later date the U.S. Public Health Service, Division of Surplus Property, will issue more detailed advice as to how surplus property may be acquired by hospitals. In the meanwhile U.S. hospitals interested in securing surpluses at the 40 per cent discount are advised to get in touch with the regional office of the Reconstruction Finance Corporation in their area.

The purchaser is required to give assurance that it is a non-profit public health institution and that the property sought is for its own use, to fill its own existing need, and that it will not be resold to others within three years from the date of purchase without the consent in writing of the disposal agency. Later the government proposes that there be a regular procedure for advising hospitals of the availability of items of surplus property. The interim procedure for the present, however, is for the individual hospital to get in touch with the regional office. Federal agencies are given first priority, with state, county and municipal governments in second place. Veterans come third and non-profit institutions are in next position. Hospitals are advised to act promptly. Although there is an adequate supply of many items, there is great pressure to remove surpluses which the government holds in quantity, and unless the priority holders are ready to place a firm order at the appropriate time, the surpluses will be sold through regular trade channels.



DEAD AND NOT-SO-DEAD FALLACIES



USNEA, THE NAME FOR THE MOSS SCRAPED from the skull of a deceased criminal, was an 18th Century "cure-all." The physician applied it to the patient's skin with a piece of rope with which the criminal had been hanged.



TODAY SOME FOLKS STILL believe that once a can of food is opened it should be emptied immediately into a porcelain container. Otherwise it becomes poisonous, they say. Perhaps you have heard this fallacy many times.

Says the U.S. Department of Agriculture: "It is just as safe to keep canned food in the can it comes in as it is to empty food into another container. The principal precautions for keeping food are — keep it cool and keep it covered."

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Provincial Notes

The Maritimes

To Notify Association of Surplus Equipment

Mr. P. T. Palmer, manager of War Assets Corporation for New Brunswick and Prince Edward Island, informed the executive of the Martime Hospital Association at its December meeting that he will advise the Association of all hospital material as it is declared surplus, in order that there may be fair distribution among the hospitals. He stated that the policy of War Assets Corporation is to dispose of material as nearly as possible in the location where it is situated. The executive committee disapproved of local hospitals endeavouring to obtain equipment directly. Mr. Palmer agreed to submit lists of equipment required by the Maritime hospitals to the head office in Montreal.

Chronic Diseases

At this meeting the need for more institutions for the care of chronic diseases was stressed. As some of the buildings which are the property of the Department of National Defence might be available for this type of work, the Association is asking that it be notified if and when such buildings are for sale, as even a temporary arrangement might be made to relieve the present overcrowding of hospitals until it is possible to build additions. Dr. R. J. Collins stated that institutions for the care of chronically ill patients are needed, not only to decrease the use of high-cost active treatment hospital beds, but also because there has been no concerted effort to treat chronic diseases as such, according to the different types of illness. A special Committee was named to seek action on this point from the provincial departments of health in the Maritimes.

School for Practical Nurses

The proposal to establish a school in a centrally-located place, possibly Moncton, to give a nine-months' course to train girls discharged from the Services as practical nurses was discussed. The Nursing Committee is to discuss the matter with the respective provincial departments of health, with a view to obtaining proper legislation for registered nurses, and also a separate act for practical nurses and nurse helpers.

Refresher Courses

It is probable that arrangements to be made this year for refresher courses for hospital administrators may result in one course being given in New Brunswick and one in Nova Scotia. Further details will be announced later.

Hospital Accounting

Arrangements are being made to assist the hospitals to develop a standard method of acounting. Copies of the 1945 Financial Review of the American Hospital Association are to be procured if possible for the member hospitals. Arrangements are being worked out whereby, through a special committee and the assistance of a firm of chartered accountants qualified in hospital accounting, experts will be available for consultation with hospitals on their accounting system, a portion of the cost to be borne by the Maritime Hospital Association.



Hon. Russell Kelly

recently appointed Minister of Health for Ontario. Mr. Kelly is one of the representatives for Hamilton.

Extensions Planned

New Waterford, N.S. Members of the New Waterford Kinsmen Club, at their regular weekly meeting, donated an incubator to the New Waterford General Hospital.

Head of Jeddore, N.S. With $18,000 to $20,000 of a required $40,000 in sight, this district in December organized a Red Cross auxiliary to work towards the establishment of a Memorial Hospital at Musquodoboit Harbour to serve the Eastern Shore district west of a line drawn through Sheet Harbour. Fulton Bayer was chosen as chairman, with Mrs. William MacKerrigan as secretary *pro tem.* Mr. John H. Rowlings has donated land for the site, which is at the west end of Musquodoboit Harbour.

Lunenburg, N.S. With Ronald G. Smith, chairman of the Campaign Committee, as host, the Lunenburg Hospital drive for funds got off to a good start at a banquet held recently, when covers were laid for 50 officials and collectors. W. F. Kinley, president of the Lunenburg Hospital Society, presided. It has been announced that to date $110,000 has been subscribed—$10,000 over the original objective. A new objective of $125,000 has been set, so that the institution may have a working capital after the building is erected.

Shelburne, N.S. At the January meeting of the town council an additional grant of $200 to the newly-organized Shelburne County Hospital Association was approved, making a total grant of $500.

Hospital Butter Not Cut

The W.T.P.T.B. has announced that restaurants and other quota consumers will have to spread their butter allotment for the present quarter over an extra month. The quota previously set for January, February and March will have to last until the end of April. The ruling applies to institutions which are allotted quarterly quotas with "a few special exceptions, such as hospitals" but not individuals. Supplies should normally improve about the end of March or early in April.



Perspective drawing courtesy of O. Roy Moore and Co., Architects, London, Ontario

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Here and There

A Medical Sphinx

THE story of one of the more remarkable of Edinburgh's long list of medical graduates is recounted by Dr. Barbara M. Humphrey in a recent number of the *Historical Bulletin* issued by the Calgary Associate Clinic as a supplement to its monthly "Historical Nights". The story is that of Dr. James Barry, a frail, delicate medico who entered the British Army in 1813, finally became Inspector General of Military Hospitals in 1858, retired in 1859 and died in 1865.

During this long career Dr. Barry served in Capetown, Malta, St. Helena, the West Indies and Quebec. Throughout this entire career as a surgeon, however, neither James' closest friends nor colleagues had the slightest inkling of his secret and it was not until his death at the age of seventy-one years that a post-mortem revealed the fact that "he" was a woman and had in early life borne a child.

Interest in this daring woman was first aroused by a letter addressed to the editor of the *Lancet* in October, 1895, by one Dr. G. Bright, U.S. Naval Headquarters, Washington, which reads as follows:

"There is a tradition to which I have seen occasional references in medical books that one or two generations ago, there was a medical officer who attained high rank in the army who was discovered on her death to have been a woman. Will you inform me if there is any ground of truth in these references?"

As the editor could not provide the information he requested his readers to do so. Thereafter many letters from men who knew her were published. Several articles and books about this strange woman have since been written.

As a student Barry was remarkable by the persistence with which "he" avoided his fellow students; whereas they wore "shooting jackets", she always appeared in a long surtout. After joining the Army a companion, Dr. Jobson, was surprised to note that Barry was afraid to go home alone in the dark through the rougher section of town. Jobson tried to teach Barry to box but "she" could never be persuaded to strike out, always keeping her arms before her chest to protect it from blows. She did, however, become proficient in the art of fencing.

Barry's first outside assignment was at Capetown. Here Lord Charles Somerset was Governor and Colonel of her regiment. She seemed to have much influence with him and it is quite possible that he knew her secret and aided her. While here a certain Thomas Munnik asked Dr. Barry to see his wife who was critically ill in labour. The civilian doctor was apparently doing nothing and although, strictly speaking, an Army surgeon had no right to take a civilian case, she immediately performed a successful Caesarian operation in the absence of the civilian doctor. A grandchild of Thomas Munnik, James Barry Hertzog, later became Prime Minister of South Africa.

While in Capetown Dr. Barry usually was seen either on horesback or driving four spirited grays, all probably gifts from Lord Charles. Her faithful Malay servant, John, remained with her until her death but his disgruntled chagrin on finding he had served a woman for fifty years was very amusing.

Lord Albermarle described her as the "most skilful of physicians and the most wayward of men". While in Capetown she fought a duel with Joshua Cloete and sustained a leg wound. Colonel Wilson writes of her:

"I recollect that, like most women, she loved to attend weddings, christenings, etc. Also I used frequently to meet her at dinner when we were all much amused at the outrageous stories she used to tell, making herself out quite a lady-killer. Also at balls or parties of any kind she was certain to attach herself to the finest and best-looking woman in the room".

Following the delivery of James Barry Munnik, she roundly denounced the medical men then practising at the Cape and insisted that the Governor make her Inspector of the Colonial Medical Board. This promotion was given and in this capacity she made it her business to look into the prison situation which no doubt was deplorable. Hence, in short order, she became Inspector of Prisons. With her blunt honesty and lack of tact is it any wonder that her enemies were legion? She also insisted that everyone at the port must be vaccinated; surely it is a mystery that she was not laid low by some stalwart Dutchman whom she insisted upon immunizing!

Most of the other articles concerning this remarkable woman came from the West Indies. Surgeon-General Longmore tells how the adjutant of the regiment stationed in Jamaica requested that the doctor discontinue visiting his wife just at the hour when he had to be on parade in the orderly room.

Lieut.-Colonel E. Rogers, formerly of the 3rd West Indies Regiment, wrote:

"In 1857 I travelled with this remarkable character on board the intercolonial steamer plying between St. Thomas and the Barbados when I occupied the same cabin, I on the top berth, she in the lower—of course without any suspicion of her sex on my part. I well remember how in harsh and peevish voice she ordered me out of her cabin, blow high, blow low, while she dressed in the morning. 'Now then, youngster, clear out of my cabin while I dress', she would say. A goat was on board to provide her with milk; she was a strict vege-

(Continued on page 82)



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Chinese Medicine

(Concluded from page 34)

incantations, to phychotherapy and exercises, other forms of treatment in harmony with the *Yinyang* theory were developed. One of these was acupuncture, the introduction of needles into various parts of the body. It is assumed that there are twelve channels which form the transportation system for the *Yin* and the *Yang* principles or humours, and so the introduction of a needle into the proper place will permit the escape of any excessive accumulation of either and thus restore the balance. Three hundred and sixty-five needling points are recognized, and in 1027 A.D. a bronze figure was cast by order of the emperor to show these points. Nine different types of needles are used, and, of course, no antisepsis or asepsis is practised, except that in some few cases the needle is first heated. They are inserted to various depths into many parts of the body, including joint cavities, the abdominal cavity, and so forth. Frequently serious, and even fatal, infections follow their use.

In addition to acupuncture several methods of counter-irritation are practised, chief among which is the burning of small cones of moxa on the skin, thus raising blisters. Here too the resulting wounds often become infected. Many persons may be seeen with the symmetrically distributed scars which result.

However, drug treatment in China, as in most other countries, has become the most universally used form of therapy. An enormous number of drugs have been used, many of them probably discovered by the alchemists, while others have come down from the primitive knowledge of remote antiquity. Drugs are related to the *Yinyang* theory, and are classified in respect to their ability to increase or decrease the amount of one or the other of the two primary principles. Legend attributes the beginnings of drug therapy in China to the Emperor Shen Nung, the Divine Farmer. He is supposed to have tasted and classified an average of one hundred drugs a day. He was deified by the drug guilds, who worship him as their patron god. He is said to have reigned for 140 years, from 2838 to 2698 B.C. Many legends have grown up around him, one of which asserts that he had a transparent stomach, and so was able to observe the effects of the drugs he took, and also to study the processes of digestion. (I am surprised that some enterprising historian has not yet claimed that Shen Nung should be honoured instead of William Beaumont for being the earliest to study *in situ* the human gastric digestion.) The first *Pen Ts'ao,* or herbal, describing 365 drugs, has also been ascribed to Shen Nung, although the internal evidence points to its composition in the first century B.C.



Hua-T'o operating on Kuan Kung, *war hero, who played chess during the curettement.*

Many other similar books, of increasing size and complexity, were composed in the subsequent centuries,, until in A.D. 1578 Li Shih-chen produced the Great Herbal, the *Pen Ts'ao Kang Mu,* in 52 volumes, containing descriptions of 1,871 different substances, of which 1,074 are from plants, 443 from animals and 354 from minerals and other substances. Along with much that is useless we find included a considerable number of drugs that are known and widely used in the West, and also a number of drugs that in recent years have been shown to possess valuable properties, such as chaulmoogra oil for the treatment of leprosy, *ma huang* from which we obtain ephedrine, and most recently *ya tan tsu,* the seed of *brucea javonica,* used in the treatment of amoebic dysentry.

Masters of Old

One cannot leave the subject of ancient Chinese medicine without at least brief reference to a few of the outstanding masters of old. One of these, and perhaps the greatest, was Chang Chung - ching, sometimes called the Hippocrates of China. He lived at the close of the second century A.D., and is especially remembered for his "Essay on Typhoid and Miscellaneous Diseases". Not only does this include much accurate observation, but Chang advocated several types of treatment of value. He used cold baths to reduce temperature. He was probably the first to use enemas. He tried to introduce a more rational form of drug therapy by writing prescriptions which included only one or two potent drugs instead of the dozen or more ingredients of the shot-gun mixture.

Another great name in Chinese medicine is that of the surgeon Hua T'o, part of whose life was contemporary with that of Chang Chung-ching. His chief claim to fame rests upon his discovery of certain anaesthetics and his skill as a surgeon. He is famous for having operated, but without anaesthetic, upon the hero of the wars of the Three Kingdoms, Kuan Kung, who continued to play chess during the curretting of the bone of his left arm, in which he had been wounded by an arrow. Unfortunately knowledge of the anaesthetics discovered by Hua T'o was not passed on.

Gradually through the centuries the practice of medicine in China became more and more stereotyped. Very few original ideas were introduced, and all the best minds in the country turned to a contemplation of the ancient ways. They looked back to a golden age in the past and at the time when the rejuvenating influence of science was giving new birth to medicine in Europe, she sank to her lowest depths in China. The ranks of the profession became filled with charlatans, quacks and imposters, men without any ethical or professional standards, who had no other aim than to reap a selfish profit from the suffering of ailing humanity.

China was ripe for a change.

(To be concluded in our March issue)

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Book Reviews

A Timely Work on Public Health Nursing

PUBLIC HEALTH NURSING IN CANADA. By Florence H. M. Emory, associate director, School of Nursing, University of Toronto, with chapters on various related subjects by seven collaborators. Pp. 543. Illustrated with charts. Price $3.00. The MacMillan Company of Canada, Ltd., Toronto, 1945.

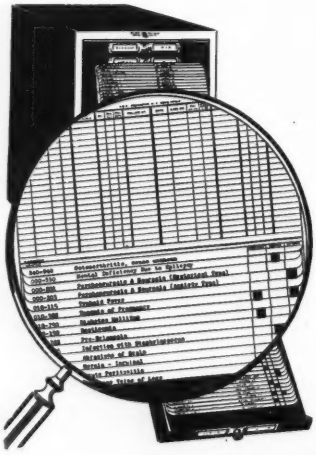
An important book which has come off the press at an opportune time is the new textbook on public health nursing by Miss Florence Emory. In this post-war period, with its far-reaching plans and extensive proposals for health legislation, it is obvious that the role of the nurse in preventive and public health development will assume an increasing importance. It is very fitting that this comprehensive volume should be largely written and edited by such an authority as Miss Emory, whose many years of experience as a teacher of public health nursing in the School of Nursing at the University of Toronto have eminently fitted her for this undertaking. As the School Director, Miss Kathleen Russell, pointed out in her Foreword, young people from every part of Canada and from many parts of the world have come to Miss Emory's classes in a continuous stream, year after year, representing every branch of public health work and representing every phase of the insistent demand for preparation for this new public health task which has been thrust upon the nurses. Miss Emory's book is based upon the course of instruction which she has provided for these students.

The major portion of the book (to p. 336) is shown by Miss Emory who, under the general heading of "Principles and General Practice" gives a broad review of the whole subject. She considers the general background, historical as well as recent, and the relationship of the public health nurse to other professional workers and the community at large. She reviews at some length the function of the public health nurse and her preparation.

Miss Emory then launches into a series of chapters on the organization and administration of public health nursing service, a section based on wide practical experience. She discusses the relative places of the official and non-official health agencies, generalized and specialized plans and the duties of the professional and lay worker in various responsibilities. Representative programmes of work are analyzed. There are chapters on supervision, on records, on nursing education and on present health insurance trends.

Part II consists of a series of chapters on specific topics, each written by an authority in that subject. Visiting Nursing is contributed by Maude B. Hall, assistant superintendent of the V.O.N.; Maternal Hygiene by Mary B. Millman, assistant professor of nursing, U. of T.; Child Hygiene, in three chapters, by Esther M. Beith, executive di-

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rector, Child Welfare Association, Montreal, and by Miss Millman; Communicable Diseases by Edna L. Moore, director of public health nursing, Ontario Department of Health; Industrial Hygiene by Sarah A. Wallace, consultant in industrial nursing, Division of Industrial Hygiene, Ontario Department of Health; Mental Hygiene by Samuel R. Laycock, professor of educational psychology, College of Education, University of Saskatchewan; and the Public Health Nurse as Liaison Between the Hospital and the Community, by Annie G. Dove, supervisor of tuberculosis and acute communicable disease nursing, formerly supervisor of hospital health service, Municipal Department of Public Health, Toronto. These are excellent chapters and add greatly to the value of the book.

Although the topics discussed throughout the work are of international application, the writers have applied them in this compilation largely to their own country. Canada has made considerable contribution to the development of public health nursing and to public health methods in general, a fact often overlooked by British and American writers. It is fitting indeed that this work, which we are sure will be used extensively throughout Canada and by many students elsewhere, should give prominence to methods which have proven so successful.

* * * *

PRINCIPLES OF INTERNAL MEDICINE, A COURSE FOR NURSES. By D. M. Baltzan, M.D., C.M., F.A.C.P., F.R.C.P. (C). Chief of Medicine, St. Paul's Hospital, Saskatoon, Concultant in Medicine, Saskatchewan Tuberculosis Sanitorium. Pp. 398, illust. Price $5.00. The Ryerson Press, Toronto, 1945.

This work has been based on a course in internal medicine given to student nurses in Saskatoon. Although the material was considerably augmented to cover the broad subject of internal medicine, the author has endeavoured to confine his text to the subject in hand, including treatment only insofar as it furthers clarity and leaving the practical aspects of medical nursing to demonstrations by nursing personnel.

The material is well written and is selected specifically for the needs of the nurse. In view of the present interest in psycho-somatic medicine, the author's chapter on psychopathological disorders will prove both interesting and helpful. The arrangement is good and the clear 10-point type facilitates reading. A few illustartions would have been acceptable, but as these are so frequently only borrowed from other works and always add considerably to the cost, the author may have been well advised to omit them.

* * * *

SURGICAL NURSING (Seventh Edition). By E. L. Eliason, A.B., M.D., Sc.D.; L. Kraeer Ferguson, A.B., M.D.; and Evelyn M. Farrand, Reg. N., B.S. Pp. 585, illust. Price $3.50. J. B. Lippincott Company, Philadelphia and Montreal, McAinsh & Co. Ltd., Toronto, 1945.

This well-known work has been considerably revised in this seventh edition. The text has been edited and rewritten to place more emphasis upon the nursing aspects of surgery, and new sections have been added. The whole text has been reset to provide two columns to a page, adding materially to the ease of reading. The book is profusely illustrated, many of the illustrations being in colour, and the text has been

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* Colebrook, L. (1933) *J. Obstet. & Gynaec.*, **40**, 977.

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brought up to date by inclusion of many wartime developments. This work should be of tremendous value to both undergraduate and graduate nurses.

* * * *

FIRES IN HOSPITALS AND INSTITUTIONS. Issued by the National Fire Protection Association, 60 Batterymarch Street, Boston 10, Mass. Pp. 50, illust. Price 50 cents. 1945.

The National Fire Protection Association, an international organization including Canadian fire protection groups, has issued a special brochure relating to fires in hospitals and institutions. Specific case reports are given, with special emphasis upon the actual cause of the fire and details of the difficulties in controlling fire or in rescuing inmates. Broken match-heads, oily waste, x-ray film decomposition (old type) and other causes are noted. Locked doors and gates, inward-swinging doors, closed valves on water pipes, open stairways, delayed discovery, inadequate exits, lack of organized fire drill and other hindrances to rapid control of fire and removal of occupants are cited. The booklet is profusely illustrated with saddening pictures of conflagrations, including a number of Canadian examples, fortunately dating back several years—the tragic Grey Nunnery fire in Montreal in 1918 when, despite unusual heroism on the part of nuns and convalescent soldiers, more than fifty children perished; the 1927 fire at the Hospice St. Charles in Quebec, when thirty-seven children burned; and the one at Shawbridge in 1922 when twelve lives were lost in the burning of the Hebrew Orphans' Home.

As examples of inadequate fire protection a number of institutional fires are cited, including the one at Falconwood Hospital for the Insane at Charlottetown, P.E.I., in 1931, the one at the National Defence Experimental Farm (convalescent home) in 1942, the Villa Maria Convent, Montreal, in 1936, and the Notre Dame de Perpetual Secours fire at St. Odilon in Quebec in 1933.

Among the example of structurally deficient buildings is listed that of the Lillian Memorial Hospital at St. Vital, Manitoba, where three patients died in 1942.

This book should be read by every administrator, every trustee and every hospital employee.

Greatest Englishman

(Continued from page 52)

Consider what it means to the hospital: the very antithesis of that which was. If health is wealth, as some one has truly said, then is a hospital a precious community treasure house, a gilt-edged bond yielding high dividends in the wealth that is health. Now the hospital is the Mecca of Hope to the afflicted, whereas before it was dreaded with the fear of "abandon hope, ye who enter here".

Consider what it means to the surgeon: accomplishments have increased a thousandfold since the renaissance of surgery, while yet the potentialities are greater and greater. Removal of that pestilence and the dread associated with it have so removed the shackles that fettered the mind and hand of the surgeon that he may now be likened to George Eliot's hero climbing the heights and ever looking and moving upward to the heights yet higher and higher.

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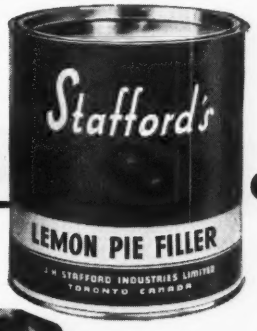
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Greatest Englishman

(Concluded from page 74)

ing fields, on land and sea, on the battlefield, in first-aid and emergency, as well as in the hospital—all come within the beneficence of Lister's principle.

It is not meant to imply that Lister alone brought about all these changes. There have been and are now hosts of men and women who have contributed to this accomplishment. The magnitude of this reformation since that day in 1865 is greater than the mind can grasp; the panorama of its future possibilties is limited only by the horizon of one's vision. But may it never be forgotten that Lister opened the door that made this vista evident.

At a dinner in Lister's honour, U.S. Ambassador Bayard is reported to have addressed him: "It is not alone the brothers of your profession, not alone your fellow countrymen, it is all these and all other humanity which, with uncovered head, salutes you."

That salutation should be indelibly engraved on the race-memory of all mankind, so that it shall never be forgotten that (again in the words of John Stewart) "There can be no doubt that in the Providence of God it was granted to Joseph Lister to do more to save life, to relieve pain, to obviate deformity, to prevent mutilation, than any other man in the history of our race".

Auxiliaries

(Concluded from page 56)

hospital district—a small central group cannot acomplish much. Permit me to suggest that ladies' aids should attempt, as far as possible, to organize auxiliary groups throughout the area. Very important is the organization of Junior Aids, to encourage younger girls to interest themselves in this important and intersting work. This enlarging of the group not only extends its effectiveness as a public relations committee but greatly enhances its ability to be of financial assistance to the hospital, and relieves the burden which otherwise falls on a few women.

10.2 Beds per Thousand Not Adequate in N.Z.

The 1945 report of the Director General of Health for New Zealand points out that there is an ever-increasing demand for hospital beds. Yet it is found that New Zealand, with 10.2 beds per 1,000 of population, has proportionately more beds than any other country. Norway and Australia come second with 8 beds per 1,000. (Canada, according to the Dominion Bureau of Statistics, has 4.4 beds per 1,000. However, a comparison of these figures is not fully justifiable because we do not know the extent to which various types of accommodation are included in the figures quoted.)

To reduce the number of acute beds the Director General makes several suggestions.

1. Employ a stricter control of admissions.
2. Adopt the plan of getting patients, both medical and surgical, up out of bed earlier than has been the custom in the past.
3. Provide more domestic help in the homes. The cost per day, or part of a day, of a domestic helper would be less than that of a day in hospital.
4. Provide more district nurses.

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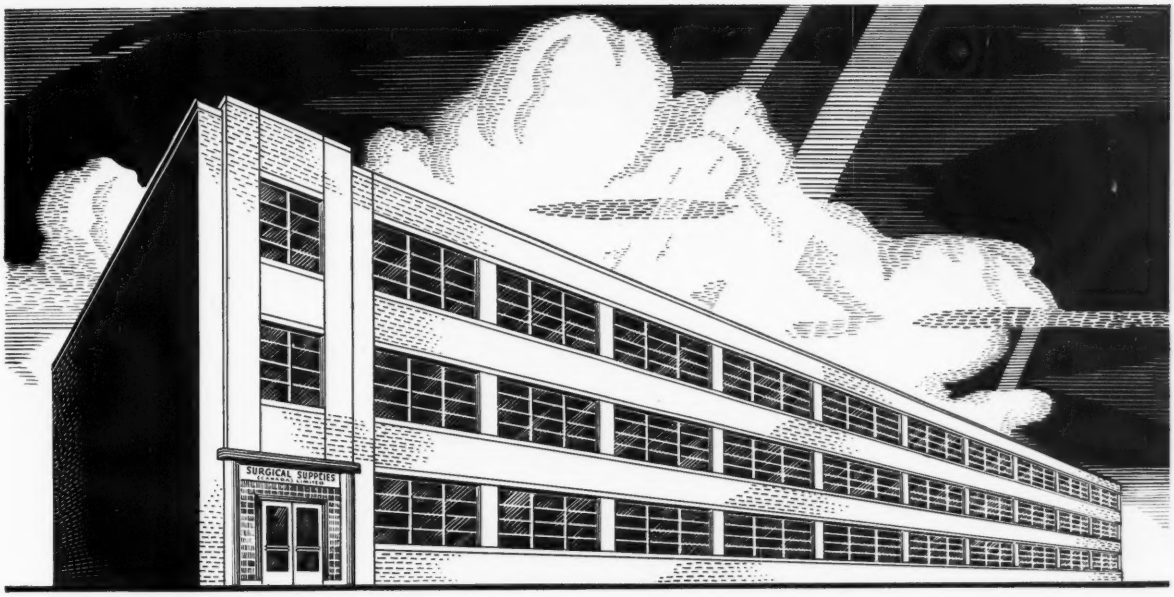


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Medical Records

(Continued from page 45)

soon as possible after admission. This also has been made the responsibility of the historian, and is recorded on the history sheet and placed on the chart within a reasonable period of time. The historian simply approaches the attending physician when she as well as he is making morning ward rounds.

Obtaining the Physical Examination

Then comes the very important part—the physical examination. The report, we realize, should be recorded on the chart as soon as possible after the admission of the patient. All of us know how depleted the medical staffs have been during the last few years and how the physicians object to being approached about notes on this or that patient. Several methods of obtaining the physical examination within a reasonable period of time have been tried —some have proven satisfactory and some not.

First of all, let us consider the different types of physicians. As far as the recording of information is concerned, all members of the staff have the same responsibility, but quite often do not care to assume it. There is the physician who enjoys recording his physical findings or any necessary information immediately after admission of his patient. Then there is the type who feels as long as he knows in his own mind where the patient has an ache or pain, that is all that is necessary.

Medical Secretary Helpful

It has been found that the small hospital is handicapped for the want of a ward secretary. The medical record department should therefore be staffed with an extra stenographer who can go to the wards with the doctors each morning and take dictation of the physical findings of patients at the bedside; this arrangement works out very nicely. Once the members of the medical staff become accustomed to calling the medical record department and asking for the service of a stenographer, the system can be handled very smoothly. But this does not take care of the physician who thinks the whole system is useless and a waste of time—perseverance with this type is essential. No doubt many of you have the doctor who, after making his ward rounds in the morning, reg-

Coming Conventions

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March 22-23—Quebec & Maritimes Conference, A.C.S., Mount Royal Hotel, Montreal.
March 26-27—Ontario & Michigan Conference, A.C.S., Hotel Statler, Detroit.
April 12-13—B.C. & Pacific States Conference, A.C.S., Multnomah Hotel, Portland, Oregon.
June 10-13—Catholic Hospital Association, Milwaukee.
June 10-14—Canadian Medical Association, Banff Springs Hotel, Banff, Alberta.
July 1-4—Canadian Nurses' Association, Toronto.
October 23-25—Ontario Hospital Association, Toronto.



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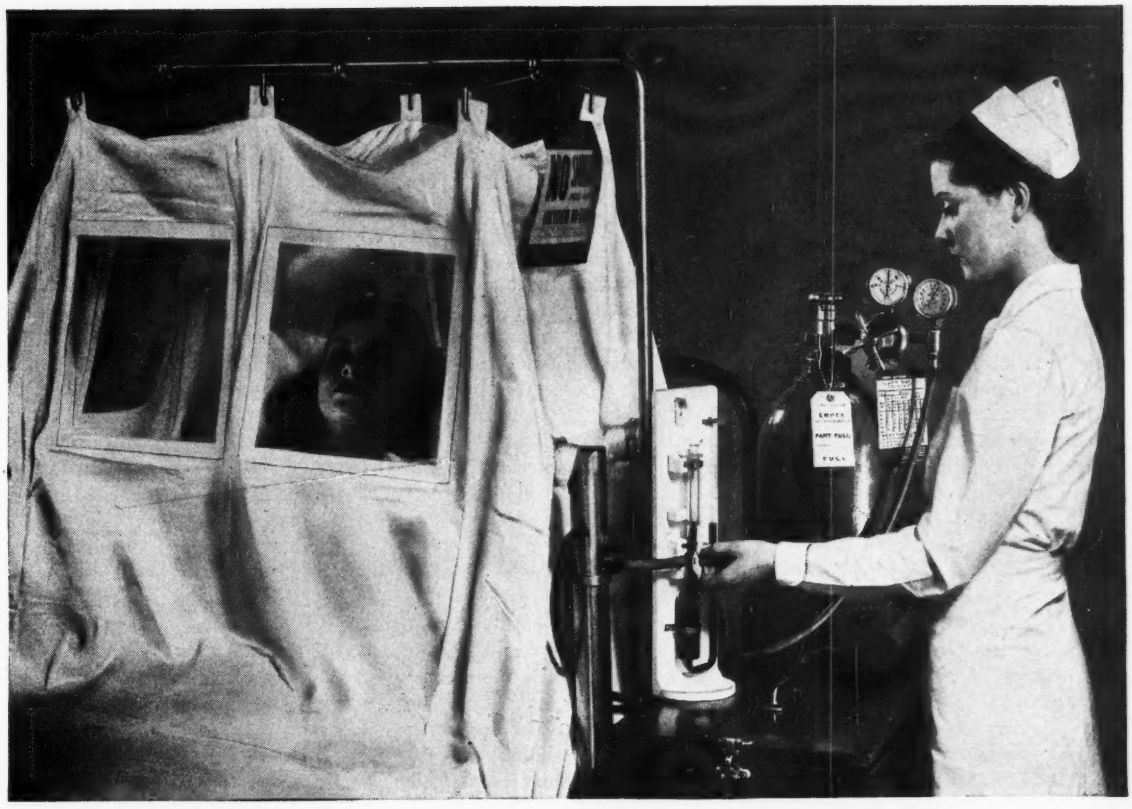
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Adequate Dosage — When oxygen is administered by tent, as illustrated, adequate oxygen can be assured only by maintaining within the tent canopy a sufficiently high oxygen concentration to overcome or relieve the patient's symptoms of anoxia. An oxygen analyzer must be used at frequent intervals to make certain that this concentration is being maintained. Such periodic checks, by revealing any need for adjusting liter flow, will also help to determine whether the tent is operating efficiently.

The Oxygen Therapy Handbook, which describes operating techniques for all types of oxygen-administering apparatus, is available without charge on request.

* References to the medical literature, or reprints when available, will be furnished on request.

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ularly comes to the record department and dictates his cases without approach. The very fact that he does not have to write his own notes acts as an incentive and is one method of obtaining fuller and better notes, for if the doctor has to sit down and write his own findings, you may rest assured they will be all too brief. Therefore we try to co-operate with the medical staff to the fullest extent.

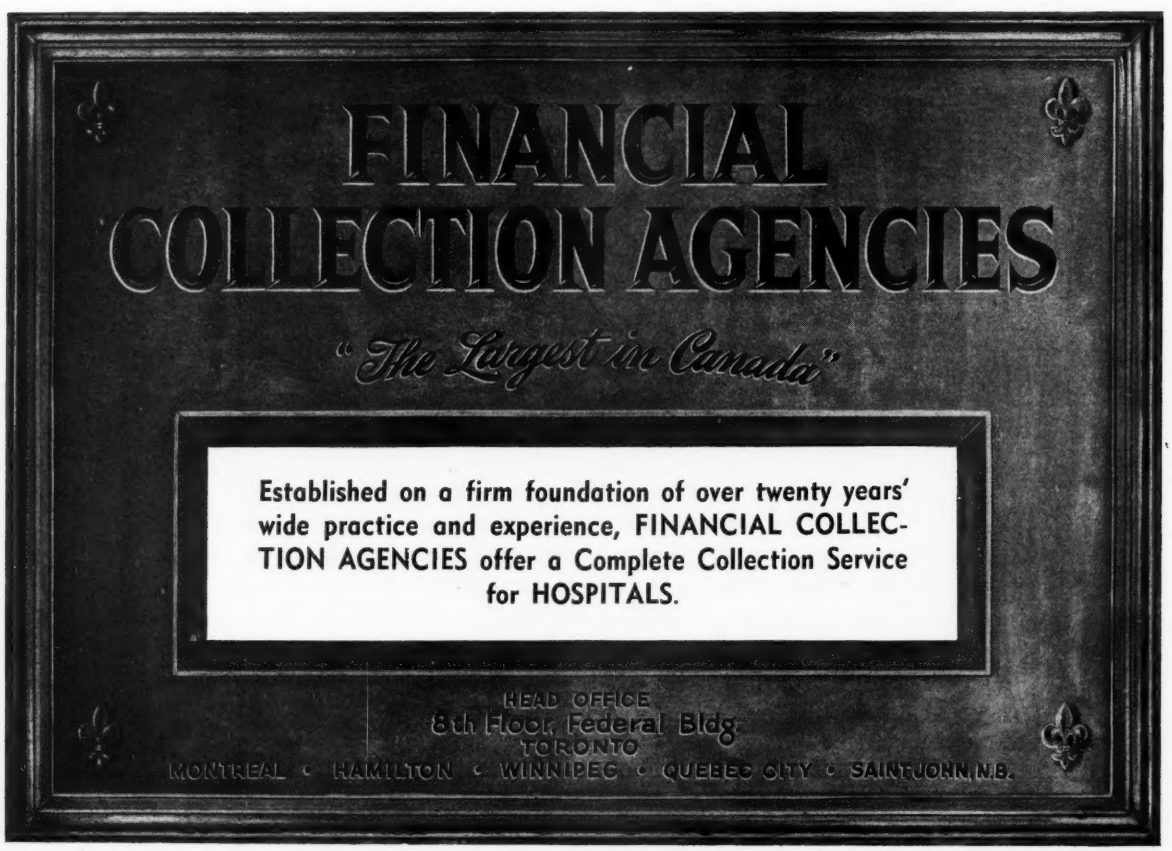
An important factor in the completion of case records is keeping in mind as far as possible the comfort of the physician while giving dictation. The medical record department should be well equipped with suitable work desks where the doctors may dictate at ease; the stenographic service should be efficient, in consideration of the time involved on the part of the physician; the physician should never be made to feel that the record staff is too busy to take his dictation at his convenience, but rather that he is doing the department a great favour by taking time to complete his charts.

One of the most important factors in obtaining an acceptable medical record in the small hospital is the location of the medical record department. This proves to be a problem in some hospitals, but it should be as close as possible to the doctor's room, or in some location where the doctors pass regularly. Thus the staff of the department may have better means of contacting the doctors, rather than having to take time to look for them on the busy wards. This convenience plays an extremely important part in obtaining necessary details for the record.

In the larger hospitals, when the chart arrives at the medical record department after discharge of the patient it is what one might consider "practically a finished product". This is not so in the small hospital and at this point a great many problems arise. In the smaller hospital the librarian's work is just beginning —it may not be signed by the attending physician; the final diagnosis may not be recorded and many other details may require checking. Again it is the responsibility of the librarian to contact the attending physician for its completion. In a great many cases, he is not more pleased over this than he was about being approached for his provisional diagnosis or the physical findings. There are certain points to consider before inviting the physician into the medical record department to complete his charts. First of all the data contained in the chart should be carefully checked in order that no report be missing, and the data should be arranged in chronological order.

To the doctor who has been interested in his patient's chart and has recorded his findings at the proper time, the completion of his chart does not prove too great a task, but to the man who has been neglectful or resentful about records, the task is now much greater than when he was first approached.

A medical record committee can solve a great many problems for the medical record department, providing the committee consists of active and interested members of the staff. A system might be put into effect whereby the doctors are advised by the record committee by letter during the first week of the month, just how many charts are outstanding under their names.



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PIONEERING IN THE MEDICAL HIGH-VOLTAGE FIELD SINCE 1879

A Medical Sphynx

(Continued from page 66)

tarian and was accompanied by a negro servant and a little dog called 'Psyche' . . . In person James Barry was short in stature, angular in figure, had a long Ciceronian nose, prominent cheek-bones and a rather lugubrious expression of countenance. I may add that she always seemed to have immense influence at headquarters and could almost choose her own station. Imperious in manner and officially dictatorial, in social circles she was admitted and respected. She was sympathetic and skilful in her profession, yet what a life of repressed emotions must have been hers—a woman too, who, it is said, gave birth to a child in her early years."

Rogers who was also the author of *A Modern Sphinx* tells how a colonel commanding a northern subdistrict gave him a startling piece of information following the publication of his novel. The colonel writes as follows:

"I was quartered as a subaltern in Trinidad when James Barry was serving there. One day a friend of mine asked me to walk with him to Port-au-Prince. 'The P.M.O. is down with a fever at the house of a lady friend but has given strict injunctions not to visit him. Nevertheless I feel bound to call and see how he is. Will you come with me?' On arrival my friend entered Barry's bedroom while I remained outside on the verandah. In a few minutes he called me excitedly, as he flung back the bedclothes, 'See, Barry is a woman.' At that moment the P.M.O. woke to consciousness and looked at us bewildered. But she quickly recovered presence of mind and asked us in low tones to swear solemnly not to disclose her secret as long as she lived. I have never before mentioned it. From her photograph you will observe the unmistakeable female character of Barry's features. But the most remarkable thing which struck most people was the way she carried her arms, with elbows in, not outward."

To William Osler we are indebted for one of the two available notes concerning her life in Canada. He wrote:

"I was interested in Barry, as our Dean D.G.W. Campbell used to tell us about her when she was stationed in Canada. She lived in the house at the corner of Durocher and Sherbrooke Streets — the one with the pillars. Dr. Campbell said she was very popular, but a martinet and lived a secluded life. He knew her well and attended her professionally but had no suspicion that she was a woman."

Dr. Maude Abbott in her *History of Medicine in the Province of Quebec* states that her full name was James Miranda Stuart Barry.

From General Chamberlain we get a picture of Dr. Barry when in Jamaica:

"Her hair was light, I think dyed, but very thin and cut close. Spectacles were not worn but high-heeled boots were. I do not think she wore a ring. She was a strict vegetarian and never touched wine or liquor, neither did she curse or swear. She had a general dislike for medical men but a queer fondness for animals, keeping several dogs and cats very happily. Rather bombastic in speech and repellant in manner but kind and anxious to do good to those not apt to be intrusive or familiar or troublesome. I believe her manner and speech were assumed to repel inquisitive associates".

In 1910 Col. Rogers again visited her neglected grave in Kendal Green Cemetery. The sandstone slab, by then prone on the grass and overgrown, gave no indication of the post-morten revelation.

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Particular note should be made that Polyself is the only type of wax recommended for use on mastic, asbestos tile, or rubber flooring. Any finish containing oils or strong solvents is ruinous to these modern floor materials. Polyself is on the list approved by the Rubber Floor Manufacturers Association.

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Pasteurization of Milk Essential

There is no excuse to-day for any hospital using other than pasteurized milk, stated Dr. W. H. Hatfield, medical director of tuberculosis control, at the B.C.H.A. convention in Vancouver. If necessary, a hospital should do its own pasteurizing, which is not a complicated procedure.

The greatest danger from tuberculosis in the general hospital arises from the unknown case. Every patient should be x-rayed if possible (the Royal Jubilee in Victoria is the only one in B.C. doing that now routinely). If that cannot be done, at least a sputum test should be done on every patient with a cough. If that is not feasible, consider all patients with a cough as potentailly infectious and handle acordingly.

Routine small films (4x5) with interpretation, but not including the capital investment, would appear to cost about 30 cents per patient. So far one in six of the British Columbia population has been 'rayed by the chest clinics and it is hoped within another year to bring that ratio to one in four.

Should Increase Budgets for Medical Schools

It is by now rather clearly recognized that the excellence of a university depends on the excellence of its faculty. Beautiful buildings may please the alumni, but the products of the minds of the faculty train students and establish the reputation of the institution. To build a great faculty requires ample funds to pay salaries, maintain buildings and a good library, provide technical help and supply equipment and materials for teaching and research. At the present time very few medical schools have adequate budgets and this, to a very large extent, has been responsible for faculty depletions. I would certainly not advocate wasting funds. A serious estimate of the needs of a first-rate medical school, admitting about 100 students per year and carrying on an excellent programme of teaching and research, both undergraduate and graduate, leads me to believe that an annual operating budget of about $1,000,000, if carefully expended, would meet present requirements. Any building programme or university hospital deficit should be provided from other sources.

—A. G. Eaton, Louisiana State University, in Journal A.A.M.C.

Hamilton Wing Re-opened

The third floor in the old wing of the Mount Hamilton Hospital has been opened to ease the pressure felt at the General Hospital during the past months. It could not be opened earlier because of the shortage of nurses. This space will accommodate 16 patients. The shortage of hospital beds in Hamilton is so acute that only the more urgent cases can be accommodated.

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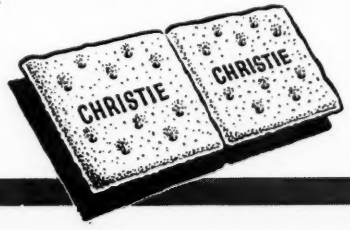
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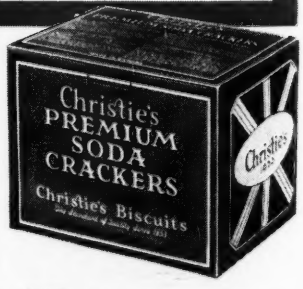


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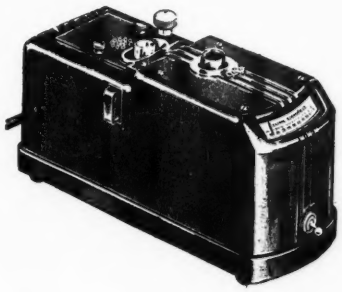
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The "Photelometer" is extremely simple to use and is easily standardized. This is done by reading the transmittancies of a number of solutions having predetermined concentrations prepared in accordance with a specific chemical procedure. These readings, when plotted on a semi-logarithmic scale against the known concentrations on a linear scale, yield an analytical (calibration) curve or standard against which the unknown solutions of that technique may be compared.

The new "Photelometer" is a barrier-layer type instrument consisting of basically a low voltage light source, an adjustable light aperture, a three-color filter holder, receptacles for tubular or rectangular absorption cells, a single photoelectric cell, and a sensitive current-measuring instrument with a 2½ inch scale. The scale reads from 0-100 in 50 divisions. The basic parts are mounted in an attractive plastic case measuring 4¾ inches high by 10¾ inches long by 4 inches wide. The 115-volt AC instruments are equipped with constant voltage transformers to supply constant intensity of light when operated on a controlled frequency power line.

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Teaching Responsibility

(Continued from page 39)

learning process should help the individual to face a situation and deal with it with confidence; to think reflectively and critically; to make decisions and act upon them; to accept consequences and assume responsibility for results; to enjoy experience and seek for more.

Fig. 1. Criteria for Evaluating Work of Nurses

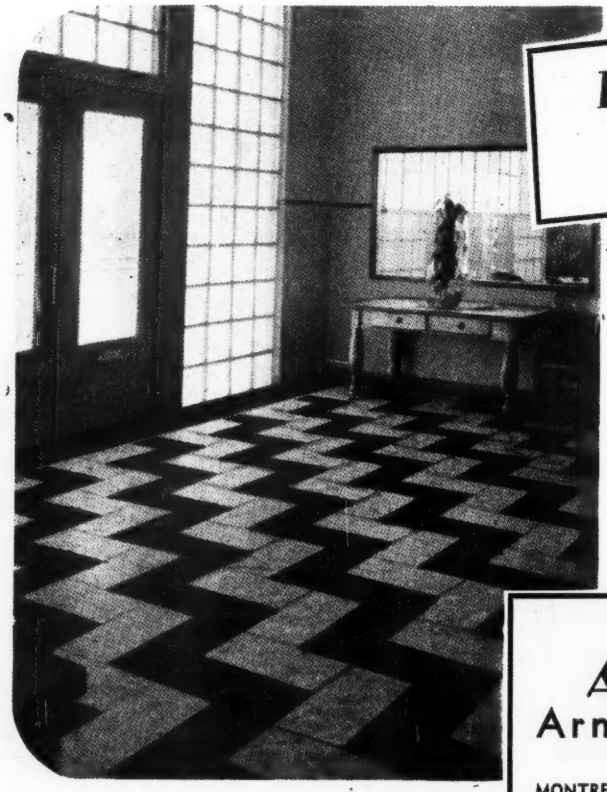
1. *Has the patient's safety been considered?*
   Have we used aseptic technique and thus prevented infection? Is the water in the hot water bottle of the correct temperature to prevent burns?
2. *Have we obtained the maximum therapeutic effect from the treatment?*
   Do we understand how such treatment may be simplified and carried out in the home?
3. *Have we conserved our time and energy?*
   How much may we allow the patient to do for herself? What effect will too prolonged a treatment have on the patient. Have we planned the work systematically?
4. *Have we been careful in our use of equipment?*
   This is a very important question, as private duty nurses are frequently accused of carelessness in the homes of their patients.
5. *Have we made the patient both mentally and physically comfortable by the work we have done?*
   Were we punctual and accurate?
   Did we work in an orderly manner?
   Have we completely finished the work before going on with something else?

All Graduate Nurses Are Teachers

The education of our student nurses offers a challenge to all graduates on the staff of a hospital. No one can escape this challenge, for we all, to a greater or less degree, must offer something to the student nurses' development, as well as to each other. It has been said that each person has an effect on all with whom she comes in contact; if that is so, all staff nurses, either by example or precept, teach the nurses in training.

To many the idea of teaching produces very unwelcome reactions. They visualize standing in front of a class and giving a lecture, and their immediate response to such a thought is "I cannot do it—I am not a trained teacher".

But if we are trained nurses, incidentally and of necessity we are teachers. We may not be "trained" in the sense of being educated as a lecturer, but during all our years of nursing we have been preparing to teach. Every time we show a student how to carry out a treatment, every time we demonstrate a technique, we are teaching by example. If



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● Entrance to a hospital . . . how important it is that it should be bright, cheerful . . . something to give confidence to patients who may enter and to those who visit them.

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we go further and give reasons for our methods, we are developing our teaching. Every time we help our nurses to plan their care of a patient we are teaching. Each time we take them aside and talk to them of the drugs or the patients, we are teaching. To think of teaching as a formal undertaking only is to lose sight of many of the most valuable ways of imparting knowledge.

Then again many will say "I haven't time for teaching". That is always the excuse of the incompetent person. On a ward—whether public or private—time and opportunity can always be found to teach. *We do not need a large audience to teach.* To take the new student who has just come to the floor and orient her, explaining her patients and their care —that is teaching. To discuss the care of the pneumonia patient and see that the mouth tray is properly set up, is teaching. To explain the new order for a drug and see that the nurse understands how to give it, is teaching. To demonstrate a new treatment, discuss the temperature of the water in the hot water bottle, even to behave in a dignified manner and refrain from personalities on the ward—that, too, is teaching.

The young nurse on the staff will gradually gain confidence in her teaching ability if she begins by demonstrating some piece of work she can do very well, such as changing a bed, giving a bath or some simple treatment. As she becomes more confident and is sure of her knowledge she can explain treatments and their effects. She must always remember that to teach means she must *know* —and that very thoroughly. In fact it has been said that the best way to learn is to be obliged to teach, for knowledge must come first.

In addition to this incidental teaching, the Morning Circle, if properly used, can be made an excellent method of teaching. The nurses can be required to read up the information on various conditions or diseases, and the head nurse can point out the essential nursing care of any particular patient.

Individual and group conferences, too, are excellent and can be very stimulating.

The formal teaching, of course, will be done by the instructors, who should keep in very close contact with all head nurses and supervisors. They should be able to link up the ward work with their teaching and a close check should be kept on the various tests being used, the outstanding diseases to be noted amongst the patients, the various pathological and chemical reactions which may be observed and all the hundred and one conditions which are always to be found and for which some scientific or nursing explanation will be necessary. No teaching is of much value if it is not carried through to the patient. And that is what we must all do.

Again, let me emphasize: *all nurses, of necessity, must be teachers.* The members of the staff where there are nurses in training must teach the students who, in turn, must learn to be teachers — teachers of health to the public and teachers in the broadest sense of the word to fellow nurses.

This is our challenge and also our privilege in the profession.

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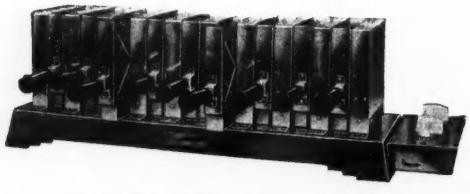
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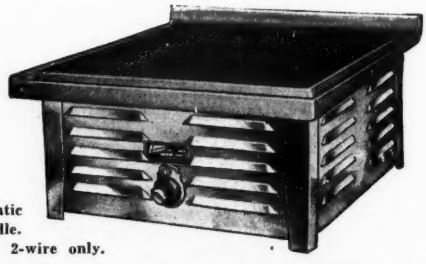


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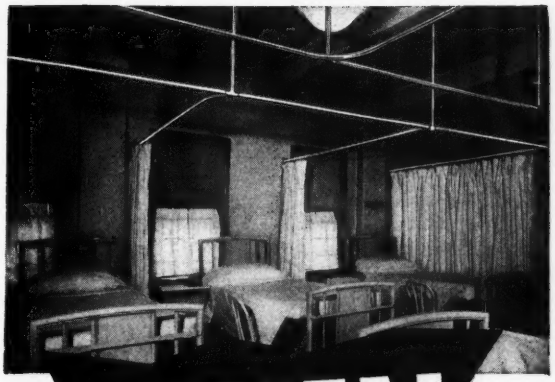
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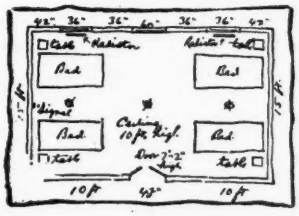
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It is now evident that All-Bran does not create "bulk" by soaking up water and, therefore, it produces no unusual colonic distension. It does not sweep out. The particle size of Kellogg's All-Bran, and the degree of laxation, have no discernable correlation. Even when ground to an impalpably fine powder, All-Bran retains its laxative characteristics.

The fact that daily consumption of All-Bran does not interfere with normal digestion is borne out by recent research, from which this and other conclusions made above have been summarized. Reprints covering this research are available upon request by writing to: Kellogg Company of Canada, Ltd., London, Ontario.

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Examination of Cerebrospinal Fluid in Syphilis

Every case of syphilis *must have* an examination of the cerebrospinal fluid.

Cases of early syphilis, treated according to a schedule requiring six months or longer, should have a lumbar puncture at the conclusion of treatment.

Cases of early syphilis, treated with a rapid form of treatment, should have a lumbar puncture six to nine months from the time treatment was begun.

Cases of latent syphilis, or of late forms of syphilis, should have a lumbar puncture *immediately*, before beginning treatment.

A lumbar puncture is to be considered as a minor surgical intervention and, like all surgical interventions, should *not* be performed *without* the consent of the patient.

As a rule, by exercising a certain amount of tact, and by giving appropriate explanation to the patient, there is no difficulty in obtaining his consent.

When, in spite of all explanations given, the patient refuses to submit to a lumbar puncture the physician *cannot* consider himself as released of further responsibility in this regard. He should inform the patient that his treatment cannot be considered as completed unless the examination of the cerebrospinal fluid is negtative, that the cerebrospinal fluid which has not been examined cannot be presumed to be negative, and that, therefore, further treatment will have to be given. At each subsequent treatment the physician should try to gain the confidence of the patient. After a time he may explain more fully to him the necessity for a cerebrospinal fluid examination. It is very rare that after a few weeks of such additional treatment and discussion of his problem the patient does not give his consent to a lumbar puncture.

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Returned officer, with long experience in Military Hospital administration, familiar with hospital records, accounting and personnel management, requires position as business manager. Box 92P, Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

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Canadian Laboratory Supplies, Ltd., Toronto.
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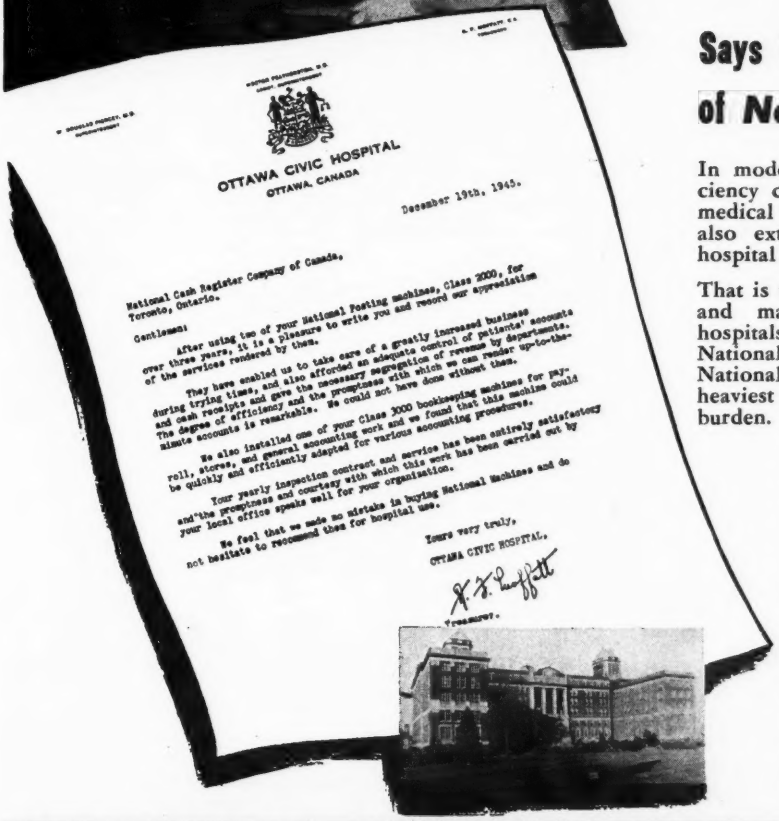
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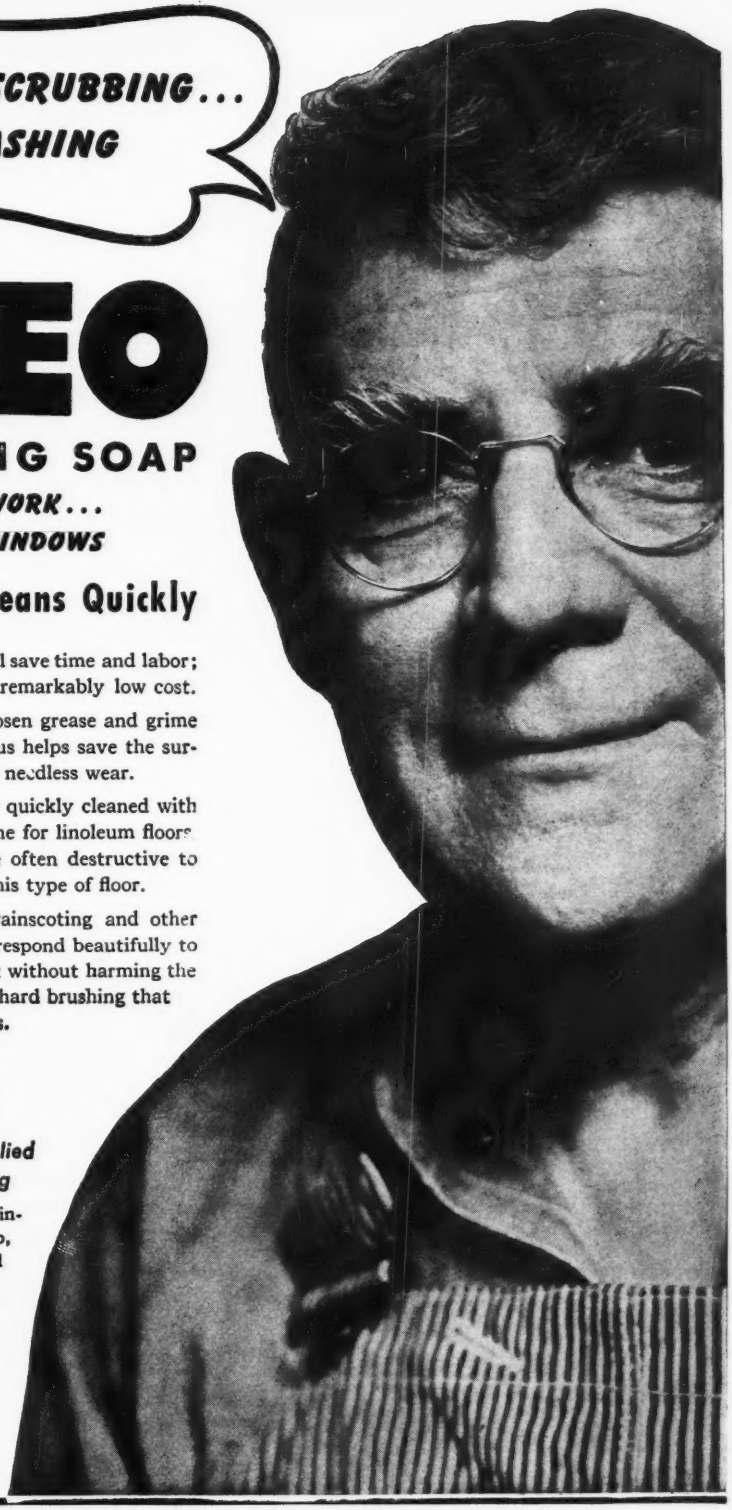
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Ingram & Bell, Ltd., Toronto.
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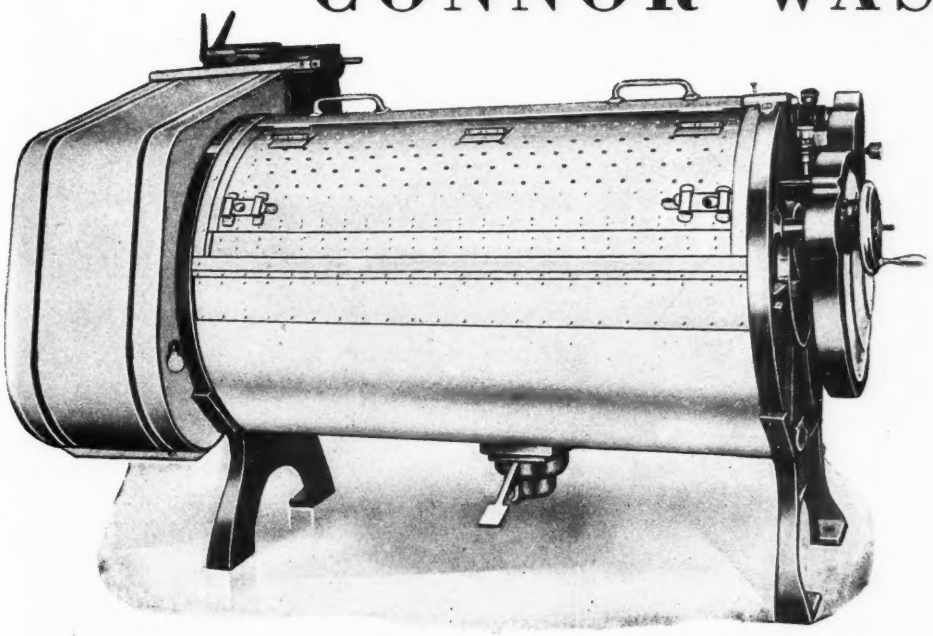
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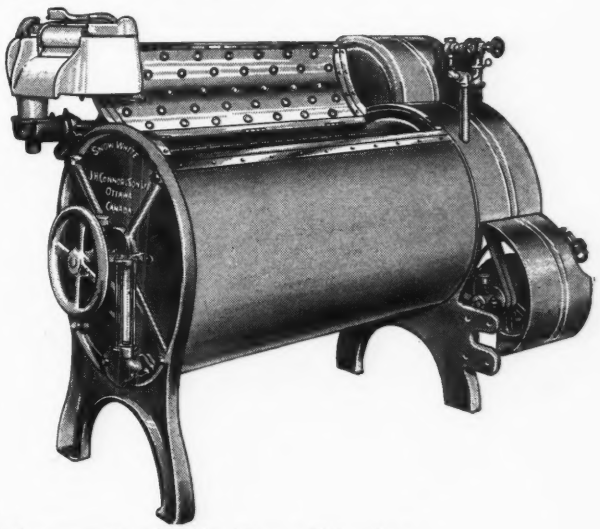
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McKague Chemical Co., Toronto.
Oakite Products of Canada, Ltd., Toronto.

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Hobart Mfg. Co., Ltd., Toronto.
Hospital & Kitchen Equipment Co., Ltd., Toronto.
S. H. Newman Co., Ltd., Toronto.
Wrought Iron Range Co., Ltd., Toronto.

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Dustbane Products, Ltd., Ottawa.
Huntington Laboratories of Canada, Ltd., Toronto.
Hygiene Products Ltd., Toronto.
Lysol (Canada), Ltd., Toronto.
Oakite Products of Canada, Ltd., Toronto.
Rougier, Freres, Montreal.
West Disinfecting Co., Toronto.
G. H. Wood & Co., Ltd., Toronto.

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Canadian Laundry Machinery Co., Ltd., Toronto.

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Dustbane Products, Ltd., Ottawa.
Huntington Laboratories of Canada, Ltd., Toronto.
Hygiene Products, Ltd., Montreal.
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Hygiene Products, Ltd., Toronto.
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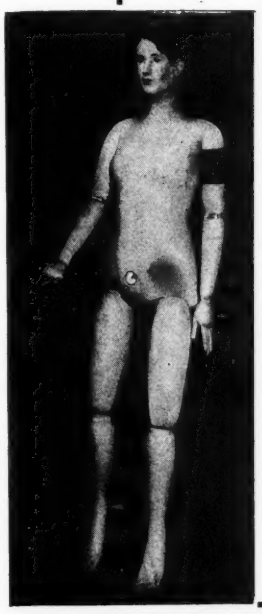
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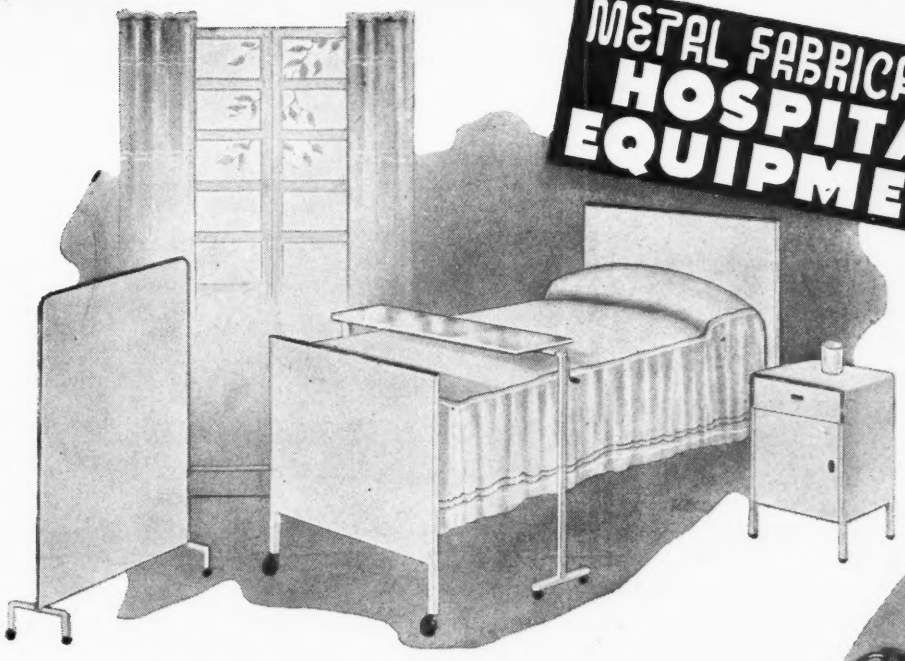
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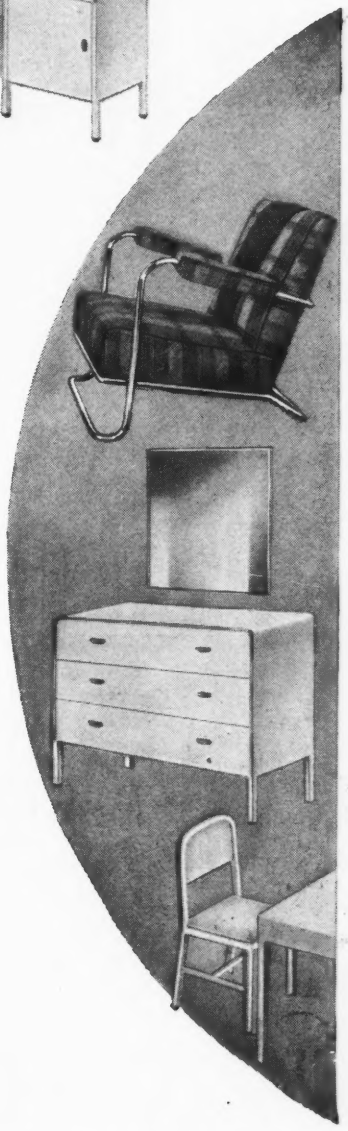
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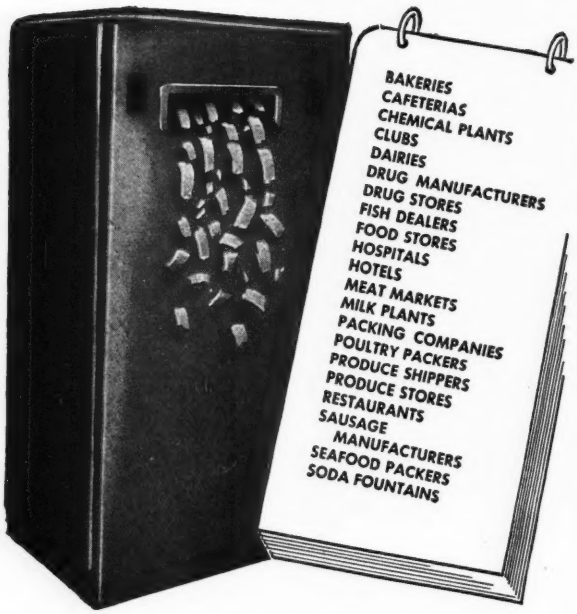
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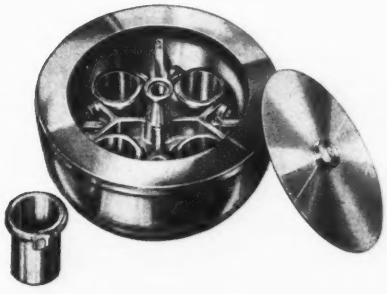
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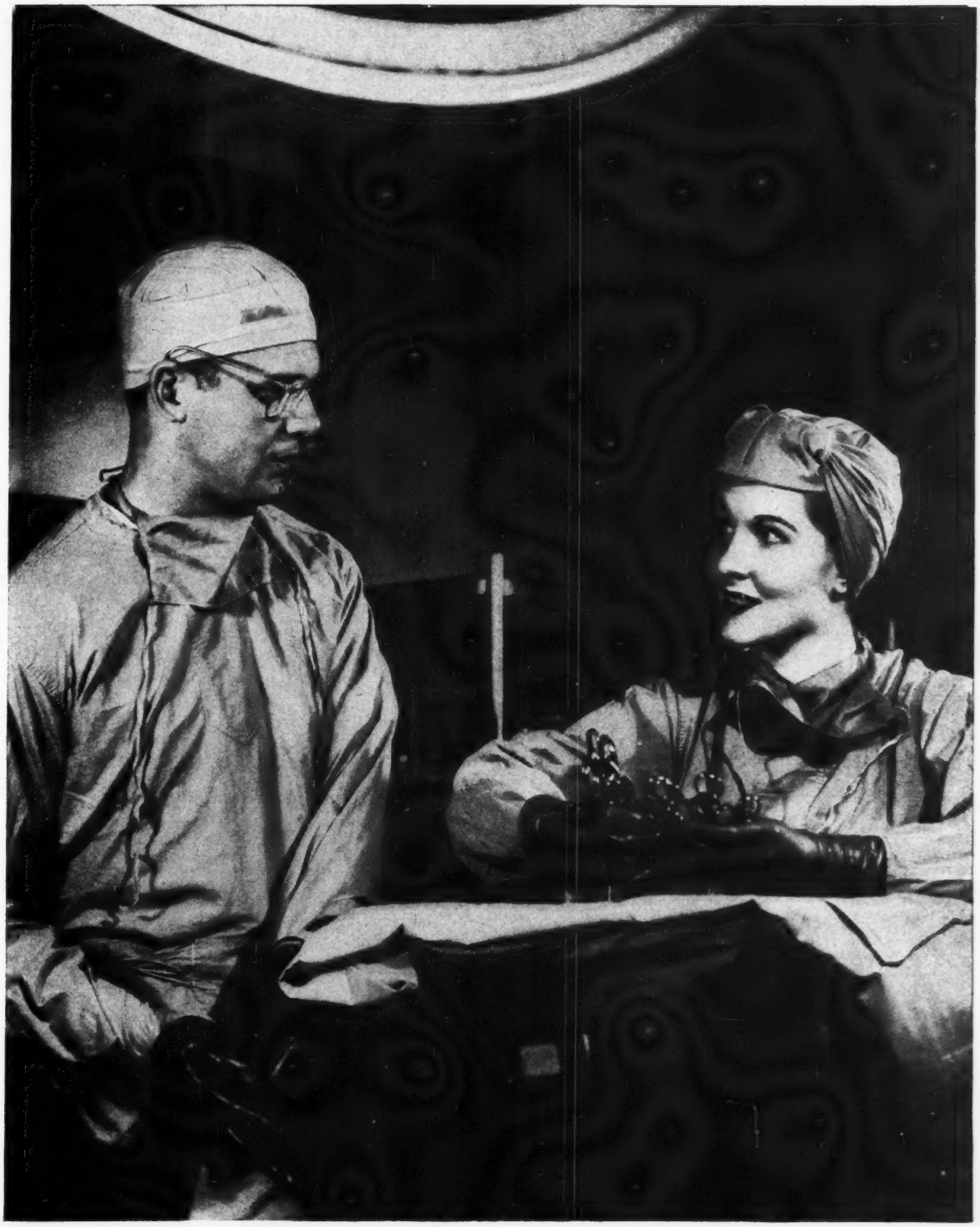
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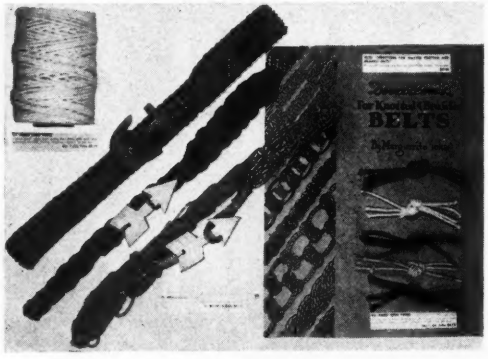
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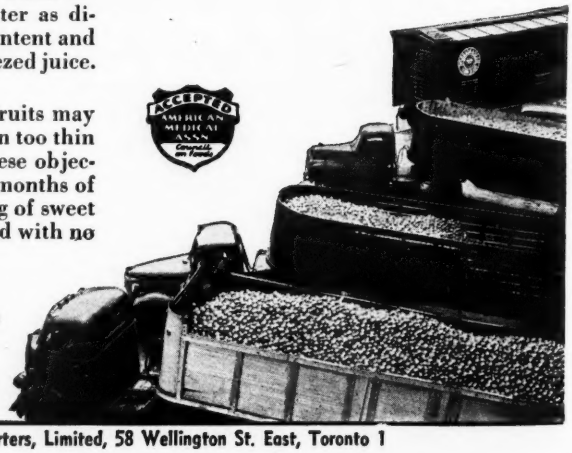
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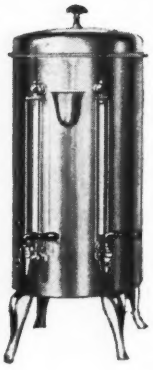
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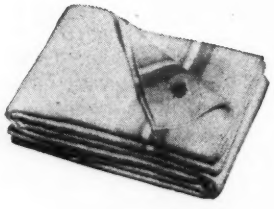


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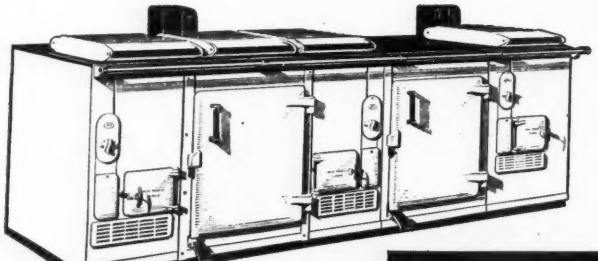
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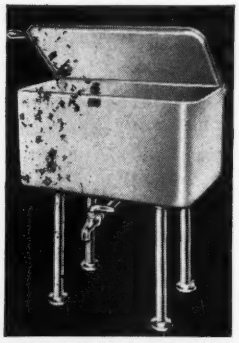
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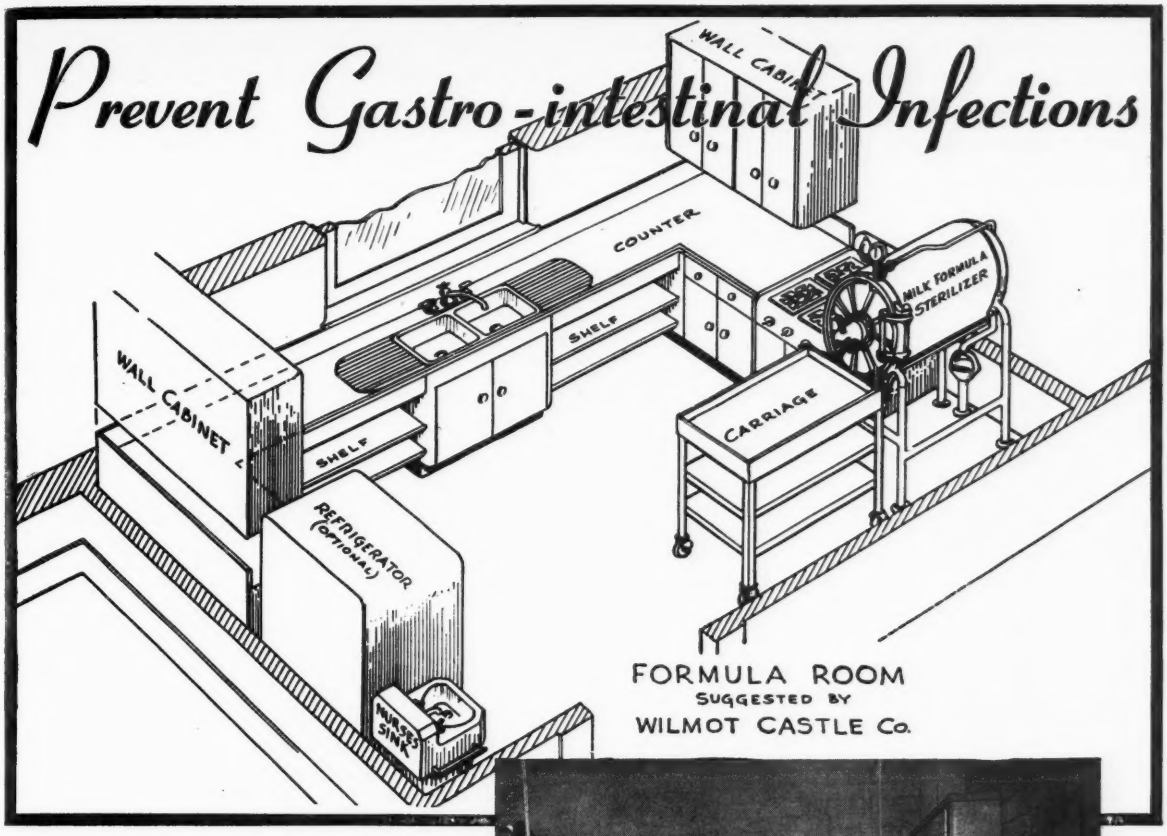
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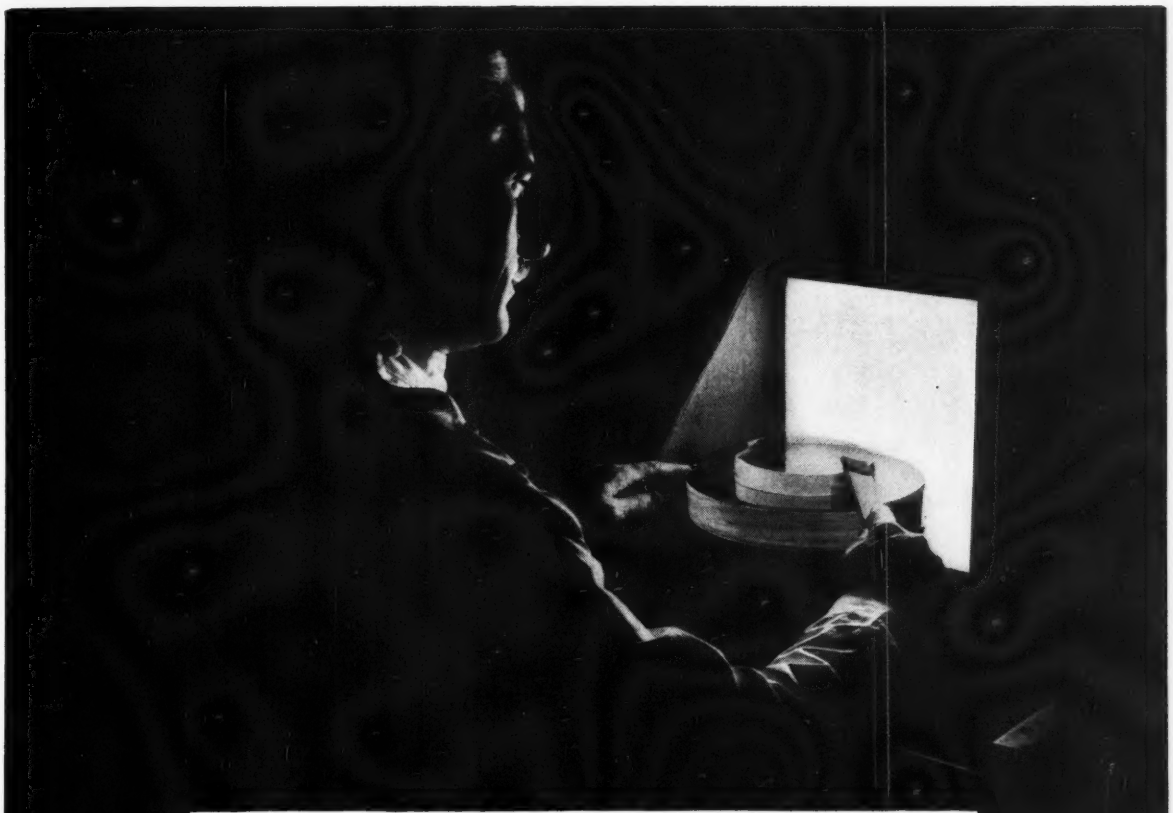
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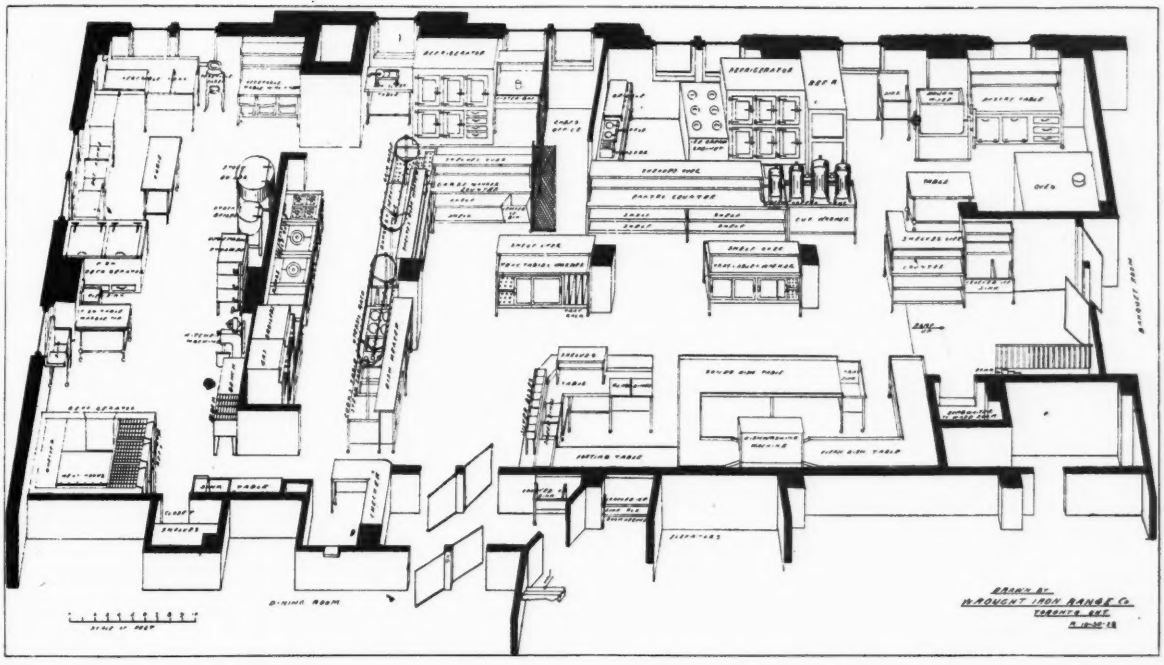
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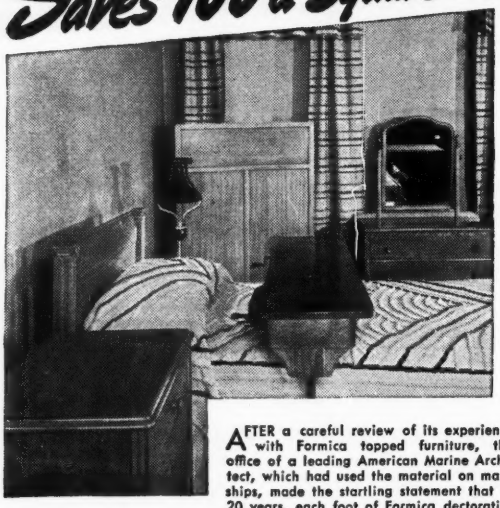
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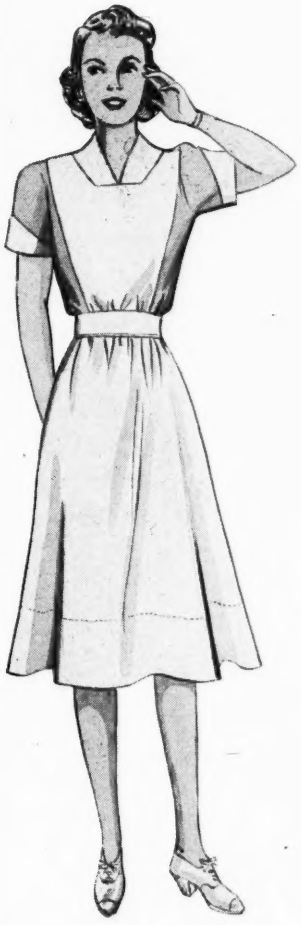
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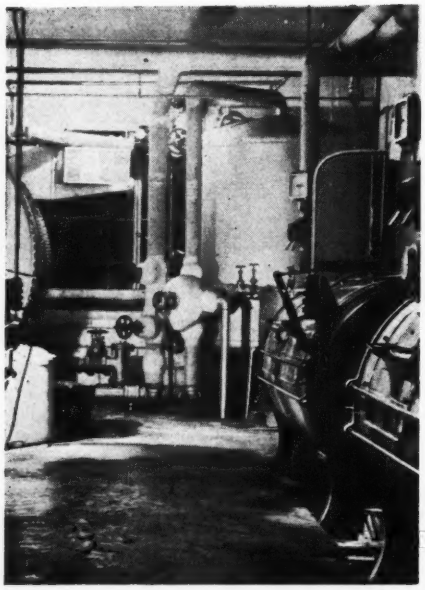
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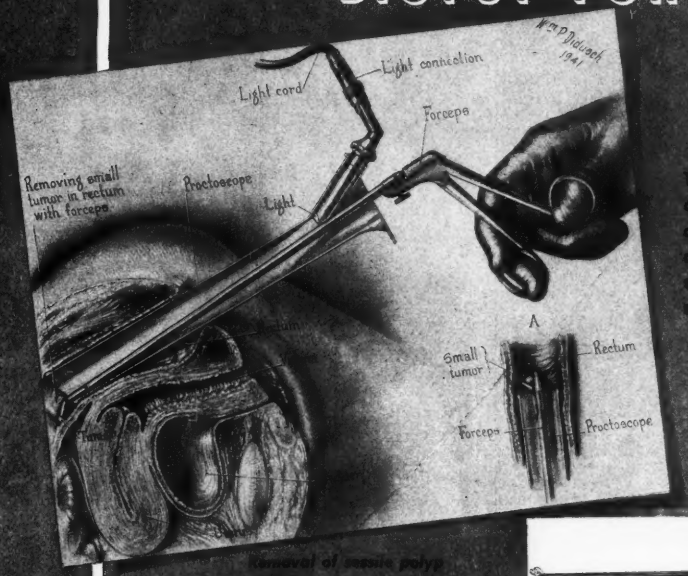
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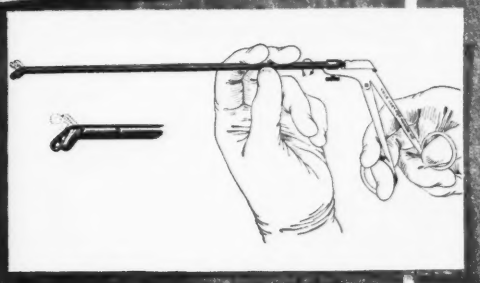
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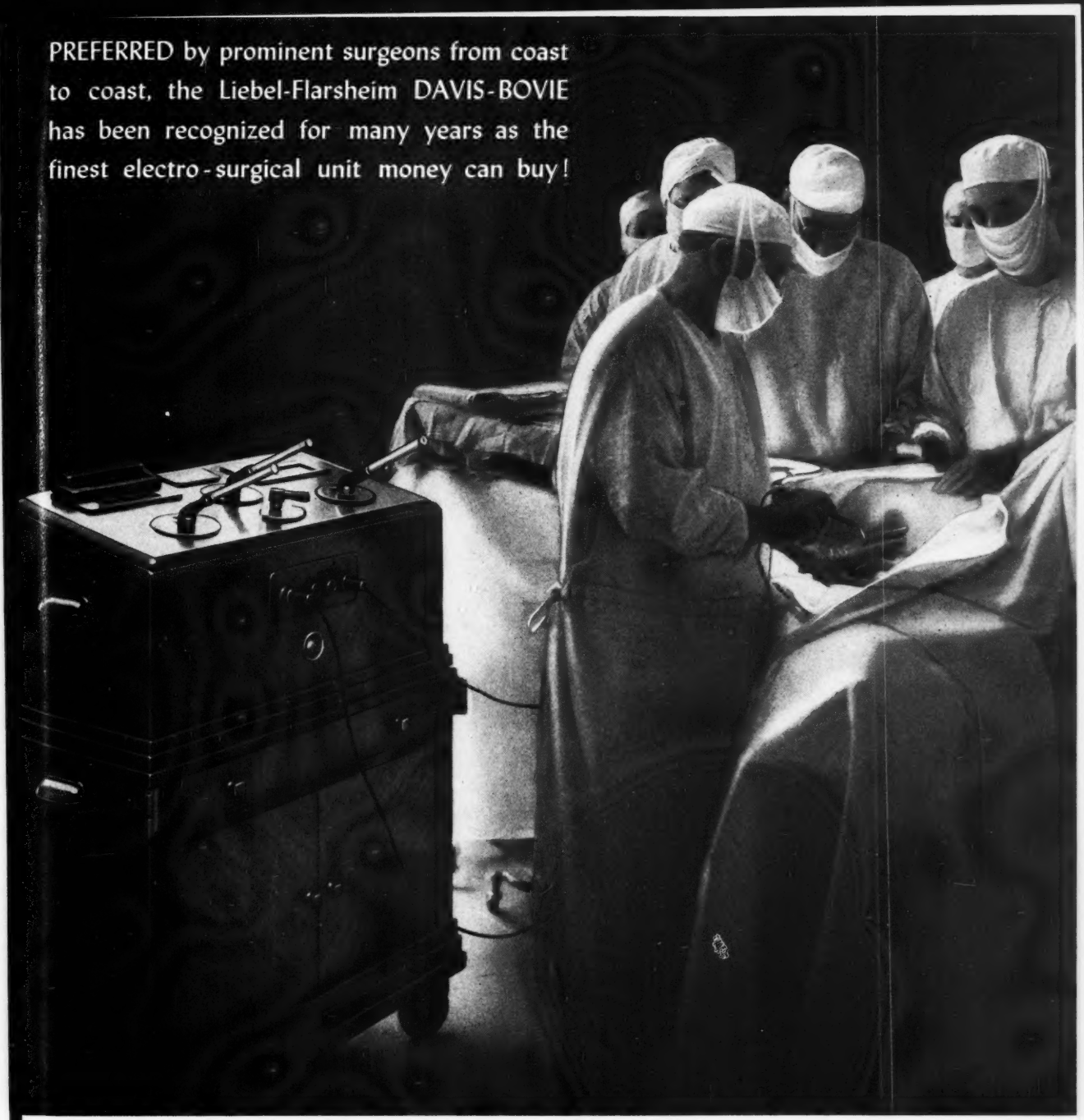
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